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ABSTRACT

Activities of the House Select Committee on Children, Youth, and Families during 1987 are recounted in this report. After a brief summary of testimony received in hearings and a description of sites visited and reports issued, the committee print provides extended summaries and related factsheets concerning hearings on: (1) AIDS and young children; (2) homelessness; (3) child abuse and neglect in America; (4) child care and employment; (5) catastrophic health insurance; (6) race relations and adolescents; (7) the crisis in foster care; (8) changing economics in the South; (9) opportunities for success for children from infancy to adolescence; (10) alternative reproductive technologies; (11) prevention of out-of-home placement; (12) AIDS and teenagers; (13) Florida's economic future and the child care crisis for families; (14) American families in tomorrow's economy; (15) children's mental health; (16) eating disorders; (17) women, violence, and law; (18) infant mortality in Illinois; and (19) the parents' role in educational reform. After a list of witnesses and others submitting testimony, selected reports are excerpted. Excerpts concern official neglect of abused children in America, current conditions and recent trends related to U.S. children and their families, federal programs affecting children, and children and AIDS. Minority views of committee members are included. (RH)

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100TH CONGRESS
2d Session

HOUSE OF REPRESENTATIVES

REPORT
100-000

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REPORT ON THE ACTIVITIES FOR THE YEAR 1987

OF THE

SELECT COMMITTEE ON CHILDREN, YOUTH, AND FAMILIES

HOUSE OF REPRESENTATIVES

100TH CONGRESS

FIRST SESSION

together with

ADDITIONAL MINORITY VIEWS

Printed for the use of the Select Committee on Children, Youth, and Families

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MEMBERSHIP

The Select Committee on Children, Youth, and Families during the First Session of the 100th Congress included 30 members, each of whom served on the Full Committee and one or two of the Committee's three task forces. The members are listed below:

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SUMMARY OF 1987 ACTIVITIES

Following is a list of the activities conducted by the Select Committee on Children, Youth, and Families during the calendar year 1987. Following the list are summaries of the major findings of each hearing, their corresponding fact sheets, and excerpts from four of the reports issued.

HEARINGS CONDUCTED

AIDS and Young Children: Emerging Issues
Field Hearing - Berkeley, California

The Crisis in Homelessness: Effects on Children and Families
Washington, D.C.

Child Abuse and Neglect in America: The Problem and the Response
Washington, D.C.

Child Care: Key to Employment in a Changing Economy
Washington, D.C.

Race Relations and Adolescents: Coping with New Realities
Washington, D.C.

The Continuing Crisis in Foster Care: Issues and Problems
Washington, D.C.

Changing Economics in the South: Preparing Our Youth
Field Hearing - Nashville, Tennessee

Infancy to Adolescence: Opportunities for Success
Washington, D.C.

Alternative Reproductive Technologies: Implications for Children and Families
Washington, D.C.

Preventing Out-of-Home Placement: Programs That Work
Washington, D.C.

AIDS and Teenagers: Emerging Issues
Washington, D.C.

Florida's Economic Future and the Child Care Crisis for Families
Field Hearing - Miami, Florida

American Families in Tomorrow's Economy
Washington, D.C.

Children's Mental Health: Promising Responses to Neglected Problems
Washington, D.C.

Eating Disorders: The Impact on Children and Families
Field Hearing - San Francisco, California

Women, Violence, and the Law
Washington, D. C.

The Continuing Infant Mortality Crisis in Illinois, Part 1
Field Hearing - Springfield, Illinois

The Continuing Infant Mortality Crisis in Illinois, Part 2
Field Hearing - Chicago, Illinois

Parents: The Missing Link in Education Reform
Field Hearing - Indianapolis, IN

Joint Hearings

Catastrophic Illness and Long-Term Care: Issues for Children and Families
(Jointly held with the Select Committee on Aging, Subcommittee on Health and Long-Term Care) - Washington, D.C.

SITES VISITED

Eating Disorders Center, Marshal Hale Memorial Hospital, San Francisco, CA. The Eating Disorders Center is a comprehensive program for the treatment of anorexia nervosa, bulimia, and compulsive overeating. Outpatient services are available. The Center also offers bulimia/aniorexia therapy groups, compulsive overeating groups, free eating disorders support groups, and free eating disorders education lectures.

Preschool Laboratory, Miami-Dade Community College, Miami, FL, provides a preschool program for children ages 2 to 5, as well as training for students considering early childhood education and child care as a profession. The program serves 67 children of students and faculty, as well as children from the community, with 400 children currently on the waiting list. The Preschool Laboratory is a non-profit organization assisted by grants from United Way of Dade County and the Child Care Food Program of the U.S. Department of Agriculture. Additional support is received from tuition fees for families based on a sliding fee scale and with subsidies from the Title XX Social Services Block Grant.

High Risk Neonatal Center, St. John's Hospital, Springfield, IL, composed of six nurseries offering different levels of critical care. The average length of stay is 20 days at an average cost of $20,000. Fifty-five percent of the infants are Medicaid eligible and 10% have no source of payment.

REPORTS ISSUED

A Report on the Activities of the Select Committee on Children, Youth, and Families, 1986 - The report includes a list of hearings conducted, sites visited, and reports issued during 1986; summaries of the major findings of each hearing and their corresponding fact sheets; and a list of witnesses and those who submitted testimony for the record.

Abused Children in America: Victims of Official Neglect - The Select Committee developed and sent to every state a survey regarding governmental and private activities to prevent and address child abuse and child neglect. This report is a compilation and analysis of the data received from all 50 states and the District of Columbia. The report includes a look at state reports of child abuse and neglect, resources available to states for child protection and child welfare services, barriers to serving abused children or children at risk of abuse, and effective prevention and treatment efforts currently used by states

U.S. Children and Their Families: Current Conditions and Recent Trends, 1987 - This report updates and expands the initial 1983 study of the same name issued by the Committee. It represents a concise statistical summary of the most recent national data on population, family environment, income, education, health and health-related behavior and selected government programs affecting children.

Federal Programs Affecting Children, 1987 - This report, prepared by the Congressional Research Service, updates the initial report issued by the Committee in 1983. It is the most comprehensive available compilation of Federal programs affecting children in the area of income maintenance, nutrition, social services, education, health, housing and taxation. Each summary includes the program's legislative authority, the agencies administering the program, a brief description of the program, and information on participation and funding levels.

A Generation in Jeopardy: Children and AIDS - This report documents the increasing threat of AIDS to our Nation's infants, young children and adolescents. It highlights the fact that the number of babies and young children with AIDS, while low today, is increasing rapidly; that sexual activity among teens places them at risk; and that AIDS among babies and young children already threatens health care and foster care systems. The report is based on three Select Committee hearings over the past year and a half, as well as recent research and reports, which have increased our knowledge and our concerns about the risk of AIDS for babies and adolescents.

SELECT COMMITTEE ON CHILDREN, YOUTH, AND FAMILIES

HEARING SUMMARIES
and
FACT SHEETS

SUMMARY OF FULL COMMITTEE HEARING ON "AIDS AND YOUNG CHILDREN: EMERGING ISSUES" BERKELEY, CALIFORNIA, FEBRUARY 21, 1987

Acquired Immune Deficiency Syndrome (AIDS) is increasingly identified as the nation's number one public health threat. Although adults constitute the majority of individuals with AIDS, it is clear that with the virus spreading among the heterosexual population, there are grave implications for babies, young children and adolescents. The Select Committee on Children, Youth, and Families held a field hearing in Berkeley, California, to examine the increasing incidence of babies born with or at risk of AIDS; the ability of health and social service systems to care for AIDS-infected infants and children and their families; and prevention efforts to reduce the spread of AIDS.

Moses Grossman, M.D., Professor of Pediatrics and Vice Chairman, Department of Pediatrics, University of California at San Francisco; Chief of Pediatrics, San Francisco General Hospital; Chairman, San Francisco Health Department Task Force on Pediatric and Perinatal AIDS, San Francisco, CA, testified that through the first week in January, only seven pediatric AIDS cases had been reported in San Francisco. He added that, while the number of babies and children with and at risk of AIDS is still small in San Francisco, compared to adults with AIDS, the number of infected children is undoubtedly significantly larger than those reported in the official statistics. In his area, he said there are more children with AIDS, a few with AIDS Related Complex (ARC), and another dozen or so born to infected women, but asymptomatic. He projected that 25-40 babies will be born to infected mothers in 1987. Heterosexual transmission will also increase and along with that increase will be rising numbers of infants with AIDS. Dr. Grossman also described recently developed guidelines regarding control of perinatally transmitted AIDS and the care of infected mothers, infants and children; the education of children with AIDS; and the control of AIDS infection in adolescents.

Robert Benjamin, M.D., M.P.H., Chief, Bureau of Communicable Disease Control, Alameda County Health Care Services Agency, Oakland, CA, testified next regarding the dimensions of AIDS globally, in the U.S. and in Alameda County; implications for AIDS in children and youth; and strategies to approach prevention and treatment. Global data show the majority of AIDS has been transmitted heterosexually and vertically (from mother to infant), unlike in the U.S. where only 4% of the total reported cases have been acquired through heterosexual contact. He described regional differences within the U.S. as well: in San Francisco, homosexual/bisexual men make up the predominant caseload (97%); in New Jersey, I.V. drug use accounts for 52%. Benjamin noted that the virus is now migrating more rapidly into the general population, with a relative slowing of transmission in the homosexual communities of San Francisco, Los Angeles and New York that have been targeted with major education interventions. He also pointed out that the geographical distribution of AIDS is shifting from urban to suburban and projected that the virus will increase in rural populations.

Dr. Benjamin told the Committee that one study conducted in Alameda County to determine the prevalence of risk of AIDS showed that 12% of attendees of a methadone maintenance program tested positive for AIDS antibodies. Another recent study, conducted "blind" to insure anonymity, and carried out to estimate prevalence in the general population, revealed seropositivity in 1 in 200 women, a rate of .5%. After the study results became public, the numbers of people coming to anonymous testing sites increased two to threefold, and increased from 10% heterosexual to 65%-75% heterosexual. Arguing that AIDS is a very serious women's health issue because of its impact on their own health as well as that of their offspring, Benjamin called for AIDS education of all women presenting at family planning, pregnancy testing and prenatal clinics; increased availability of voluntary confidential testing; and condom use to avoid infection. He emphasized that, while no cure or satisfactory treatment currently exists, AIDS is a preventable disease.

John R. Williams, Executive Director, Children's Hospital at Stanford, Palo Alto, CA, addressed issues facing hemophiliac children who have AIDS or have been exposed to the virus because they received treatments of clotting factor concentrates between 1981-1986 that were contaminated with the AIDS virus. Concentrates can now be heat-treated to deactivate the virus, and testing of the blood supply has reduced the likelihood of the presence of the virus in the concentrate supply. Williams reported that, of the estimated 20,000 persons with hemophilia in the U.S., 288 hemophiliacs have been diagnosed with AIDS and studies indicate that 70%-90% of all hemophiliacs have been exposed. Stanford Children's Hospital serves 130 hemophiliac boys and young men. Six patients have developed clinical AIDS; five have died. Most of the patients live daily with the fear that they also will develop the disease. Williams also cited the problems of hemophiliac young adults who are having families: 10%-15% of the spouses of hemophiliacs are antibody positive, and babies born to antibody positive mothers carry 50%-80% risk of being antibody positive.

Williams called AIDS an additional financial catastrophe for hemophiliacs whose treatment costs can range from $1000 to $75,000. One child with AIDS had costs of $250,000 for the last year before he died. The hospital has developed education for hospital staff on how to care for the children and to protect themselves from infection, and education of home health care workers who were initially reluctant to care for AIDS children. Williams also reported confronting problems for siblings who are socially isolated by those who fear the disease.

Jean McIntosh, M.S.W., Assistant Director, Program Resources, County of Los Angeles, Department of Children's Services, Los Angeles, CA, documented large increases in reports of child abuse and neglect in the past five years, particularly in the numbers of high risk children needing child protective services because of substance abuse and sexual molestation which place them at high risk of AIDS. She cited an increase in dependency petition filings because of excessive drug use by a parent, from 241 cases in 1981 to 2857 cases in 1986 (1100% increase). Dependency petition filings because of drug ingestion by minors or infants in drug withdrawal similarly increased from 132 cases in 1981 to 1363 cases in 1986 (a 933% increase). In 1981 substance abuse related referrals represented 4.09% of the total 9,133 petitions filed; in 1986, they represented 21% of the total of 20,096 filings.

McIntosh explained that the increasing difficulty in recruiting foster families for the care of young children generally has been compounded by their fear and lack of preparation to care for medically fragile children. Young children are also increasingly being placed in group homes rather than in foster families. The number of foster family spaces for infants and toddlers has remained approximately even at 7,800 over the past 6 years, while the number of spaces in group homes and institutions has increased from 70 in 1980 to 170 currently (64 more spaces will open in three new facilities by April 1987). In November, 1982, the Los Angeles County shelter for abuse and neglected children had an average daily population of nine children under age 5; in November, 1986, the average number in the shelter's nursery was 90. She submitted that young children with or at risk of AIDS may have less chance for foster or adoptive placement with a family.

She also addressed special problems of sexual abuse and AIDS and of adolescents in care. McIntosh stated that child welfare professionals may soon be confronted with young children not only traumatized by sexual abuse but who also face life-threatening medical issues. With regard to teens, McIntosh discussed the child welfare system's responsibility to educate them about the risk of AIDS, as well as to establish systems responsive to their needs.

Sylvia Fernandez Villarreal, M.D., Physician Specialist, Department of Public Health, City and County of San Francisco; Board of Directors, California Children's Lobby, Subcommittee on Children and AIDS; Member, San Francisco Department of Health, AIDS Minority Task Force, testified regarding issues concerning ethnic minority children and AIDS. Citing mid-January Centers for Disease Control (CDC) data, she reported that, of the 416 pediatric AIDS cases, 60% are black and 23% are Hispanic, though these ethnic minorities comprise only 11% and 7% of the total U.S. population respectively. She noted that most of the infants and children become infected during pregnancy, and that 86% of children with AIDS have at least one I.V. drug-using parent. She also stated that the disparity in representation of minority children with AIDS reflects their living "in the marginal society of poverty, low education and drug abuse." She recommended greater attention to issues concerning the medically fragile child, the AIDS child in foster care, and improvement of circumstances so that fewer children and families are living at the margins.

William Barrick, R.N., M.S.N., Program Manager for AIDS Services, Alta Bates/Herrick Hospitals, Berkeley, CA, also reported signs of increasing problems citing the recent births of four seropositive newborns. Two women out of 28 tested thus far for the AIDS antibody tested seropositive in a new program developed by Alta Bates' High Risk Pregnancy Program. Barrick urged special attention to the education of women and adolescents -- those who are already in high risk categories as well as others. He noted that California still has an opportunity to prepare for the AIDS crisis among babies, young children and pregnant women, and recommended infant services to deal with increasing numbers of sick and dying children; increased education of perinatal and pediatric health professionals; and development of home and other alternative care arrangements to provide more appropriate and cost-efficient care. Barrick stated that, while it would be premature to project costs of hospital care for children with AIDS since only 24 children with AIDS have been reported in California so far, the costs for care of adults range from $60,000 to over $140,000 per case. He added that the use of home health and social services could save 50%-75% in comparison to admission to an acute care hospital without such services. Alta Bates has begun a program, AIDS Care, Community Education, and Social Services (ACCESS) offering comprehensive services using a case management approach to provide assessment, planning, treatment, referral, monitoring and advocacy. John Swartzberg, M.D., F.A.C.P., Co-medical Director, Alta Bates/Herrick Hospital AIDS Services, who accompanied Barrick, testified that medical systems are not at all prepared to handle AIDS, adding that the range of medical and psychological services needed for persons with AIDS does not fit current models of U.S. medicine, and that alternatives must be developed.

Marcia Quackenbush, M.S., Coordinator, Youth and AIDS Prevention Program, AIDS Health Project, University of California, San Francisco, concluded the hearing by addressing the need to educate children and youth in developmentally appropriate ways regarding AIDS. She explained that adolescents need to be targeted for many reasons, including their need to have prevention information before they initiate sexual activity. As of late January, 1987, 131 (less than 1%) of U.S. AIDS cases were among 13-19 year olds and 6198 (21%) were among 20-29 year olds. Current reports indicate a mean incubation of about 5 years for AIDS, suggesting that many individuals diagnosed in their early twenties were originally infected in their teens. Many teens engage in high-risk sexual activities: among high school students, 50% of women have had sexual intercourse, and 16% of these report 4 or more different partners. Further, there are over 1 million teen pregnancies annually and an estimated 1 in 7 teens have a sexually transmitted disease. The same activities which cause unwanted pregnancy and most sexually transmitted diseases can also transmit AIDS.

She advocated strongly for developing AIDS education programs for younger children. It is important to reach any students who might engage in risk behaviors before middle or high school and to assist younger children, especially in areas with a high incidence of AIDS, in understanding the concept "not casually transmitted." In addition, 5th and 6th graders may actually be more receptive to AIDS prevention information than older students. She reported that materials for high school students are beginning to appear, but that specific concepts and materials to teach young children are not widely established or available. Quackenbush also emphasized the need to develop alternative prevention strategies for groups such as minority youth, young people who are not in school and youth in institutions. With regard to younger children, Quackenbush noted that one real risk of AIDS transmission for children is that of being sexually molested by an HIV-infected adult, and that an approach to AIDS prevention with children should include the promotion of programs to prevent child sexual abuse.

SUMMARY OF FULL COMMITTEE HEARING ON "THE CRISIS IN HOMELESSNESS: EFFECTS ON CHILDREN AND FAMILIES" WASHINGTON, D.C., FEBRUARY 24, 1987

On February 24, 1987, the Select Committee on Children, Youth, and Families held a hearing entitled, "The Crisis in Homelessness: Effects on Children and Families." Children and families have become the fastest growing segment of the homeless population. This hearing examined new findings from communities across the country about the academic, health, social and psychological consequences of homelessness for children and their families.

Yvette Diaz, age 12, a resident of Hotel Martinique, a New York City shelter for the homeless, began the hearing by describing how she lives in two rooms with her mother, two sisters age 9 and 7, and a 3 year old brother. She told the committee that living there is dangerous, with "all kinds of people who are on drugs or crazy." Many things happen in the hotel that make her afraid, there is no place to play on the street, and it is not even safe when she plays with friends from other rooms on her floor. She attends an extended school program in the afternoons established by the New York City Board of Education for "homeless" children. The program helps with homework, gives computer lessons, provides arts and crafts, dancing, gym and game room and a hot dinner every night before the children return to the shelter.

Valerie Mascitti, Director, Homeless Project, Advocates for Children of New York, Long Island City, NY, accompanied Yvette. She stated that the New York Human Resources Administration houses over 4,000 families, and 11,000 children in hotels, shelters and other forms of temporary housing, and described the harmful effects of these environments on the children's education. Due to the constant movement of many families from shelter to shelter and the lack of appropriate food and clothing, some children do not get to school at all. For others, school attendance is sporadic. According to Mascitti, children become fearful of going to school, afraid that when they return to the hotel or shelter their family will be gone. Parents also fear for the safety of their children, afraid of harrassment and physical harm at the hands of other children or teachers, administrators and school bus drivers. As a result, children fall behind academically and, according to Mascitti, the system may simply be preparing the next generation of homeless, institutionalized families.

Lisa and Guy McMullan and their children, Jamie, Ryan, Morgan and Ryder, ages 10, 7, 3 and 2, of Dundalk, MD, presented testimony on their recent experience of becoming homeless. Lisa described the family's experience of losing their home in Miles City, Montana, after the farm crisis brought a decline in the town's economy. The family subsequently moved to Washington, DC. After a stay with Guy's mother in her crowded basement apartment, the family moved to Baltimore, where both parents found work and were able to rent an apartment. Guy was laid off and Lisa's low wages could not pay for child care. They could not pay the rent and the family was evicted.

Lisa had great difficulty in finding a shelter that would house a two-parent family. After an intense search, the family was housed in a Baltimore Salvation Army family shelter for four weeks. The overcrowded conditions, the lack of privacy and safety, and the food were not conducive to family life. She described the stress associated with insecurity and the family's need to maintain order and control in their lives. She also said that she and her family felt worthless because they suddenly had no home.

Maria Foscarinis, Washington Counsel, National Coalition for the Homeless, Washington, DC, in introducing the McMullan family, stated that her organization's guiding principle is that in a civilized society, all persons should be afforded the basic resources necessary to survive: decent shelter and adequate food. Foscarinis testified that families comprise over 30% of the homeless population and current efforts to provide even minimal emergency assistance to homeless families are woefully inadequate.

June Bucy, Executive Director, National Network for Runaway and Youth Services, Washington, DC, reported that many teenagers become homeless when their families are turned into the street. Most shelters for homeless families will not accept older teens, especially boys, because they are disruptive and seem a threat to other residents. As a result, many young people who are homeless and alone must resort to illegal ways of securing food and shelter. In addition, studies of street youth that look at educational attainment find the youth to be below grade level for their age, discouraged by the system, and probably cut off from achievement in traditional school programs. Bucy said that in our highly technical society, this lack of basic skills may be the most serious of all problems facing homeless youth.

Kay Young McChesney, Director, Homeless Families Project, University of Southern California, Los Angeles, CA, led off the second panel by describing her new findings from interviews with 90 homeless families living in 5 shelters geographically distributed throughout Los Angeles. Her main finding was that families are homeless because they are poor, not because they have psychiatric problems or are alcohol abusers. She described these families according to four categories: unemployed couples; mothers leaving abusive relationships; AFDC recipients; and mothers who were homeless as teenagers.

During 1985-86 there were no government-funded shelters for homeless families in Los Angeles County, and for an estimated 10,000 homeless teens in Los Angeles, there were only 45 available shelter beds.

In addition to the disruption in family life caused by homelessness, four effects on children were observed: developmental motor and language delays; developmental regression among older children; stress effects including excessive crying and clinging; and physical health effects resulting from exposure to the elements.

Nancy A. Boxill, Associate Professor, School of Social Work, Atlanta University, Atlanta, GA, presented new findings of the effects of homelessness on families from interviews with homeless families using emergency night shelter in Atlanta. She testified that the daily routine of these homeless families begins at 6:30 a.m. when they must leave the shelter taking all their belongings and a cold snack with them. Preschool children, accompanied by their mothers, take public transportation or are taken by police vans to the children's shelter across town. Only 30 slots are available on a first-come basis. Their mothers cannot stay with them, but come for them at 7:00 p.m. when the night shelter opens.

School-aged children, knowing that they may not remain in one school, often avoid social interaction and involvement in school activities because they do not want to be identified as being "homeless". From 3:30 p.m. on, they must occupy themselves until the night shelter opens.

Boxill described homeless children's lives as "out-of-order." She concluded that homeless children have an intense desire to proclaim and protect their self-worth; exhibit exceptionally assertive behavior, often perceived by others as negative; and exhibit a profound ambivalence about their place in the world, since no part of their day is predictable. Boxill's findings also showed that these children are over-anxious, sad, angry, lonely, depressed, frustrated and cautious, and are at high risk for succumbing to poverty.

James D. Wright, Principal Investigator, presented findings from the National Evaluation of the Johnson-Pew "Health Care for the Homeless" (HCH) Program. This demonstration project, funded by the Robert Wood Johnson Foundation and the Pew Memorial Trust, has established health care clinics for homeless and indigent people in 19 large cities. Wright presented findings based on the experiences of 50,000 homeless persons seen in the clinics from spring, 1985 to December, 1986. Of these, 15% were members of homeless families and 10% were children under 15 years of age. Health data for 1,028 homeless children who had been in the HCH projects more than once showed the most common disorders to be: minor upper respiratory (40%), minor skin ailments (20%), ear disorders, mostly otitis media (18%), gastrointestinal problems (15%), trauma (10%), eye disorders (8%), and lice infestations (7%).

According to Wright, homeless children are more ill than domiciled children. Their rate of chronic physical disorder (16%), is nearly twice that observed among ambulatory children in general, and include: cardiac diseases (3%), anemia (2%), peripheral vascular disorders (2%), neurological disorders (2-3%).

For adults, virtually every disorder is more common in homeless clients except for obesity, cancer and stroke. Wright attributed the large differential in health status between the homeless and the general population to homelessness itself and to the extreme poverty that characterizes the homeless group.

Tricia Fagan, Outreach Coordinator, Association for Children of New Jersey, Newark, concluded the hearing with testimony that more than 50% of the estimated 25,000-30,000 homeless people in New Jersey are children. She cited evictions as the number one reason for family homelessness in New Jersey. Fagan testified that because of the limited number of family shelters, and because their parents could not find an affordable place to live, at least 1200 children in New Jersey were placed into foster care this past year. These children represent 18% of the state's foster care caseload. However, when children are placed in foster care, the mother loses her AFDC benefits, placing her in a precarious situation while she searches for housing. Of the foster children whose records were examined, 40% were found to be in foster care with homelessness as the major or secondary factor leading to placement.

Ciro A. Scalera, Executive Director, Association for Children of New Jersey, joined Fagan in asserting that several federal and state programs are failing to meet their stated purpose of support and preservation of families, and a disproportionate number of today's homeless families are victims of that failure.

THE CRISIS IN HOMELESSNESS: EFFECTS ON CHILDREN AND FAMILIES

A FACT SHEET

HOMELESSNESS AMONG FAMILIES WITH CHILDREN IS INCREASING

* Estimates of the number of homeless in America range from as few as 250,000 (HUD, 1983) to as many as 2.5 million (Hombs and Synder, 1982), with estimated annual increases in homelessness ranging from 10% to 38% (GAO, 1985). Families with children are the fastest increasing homeless group and now comprise nearly 38% of all homeless persons in the U.S. (U.S. Conference of Mayors [U.S.C.M.], December, 1986.)

* In all but 2 of 25 cities surveyed, the number of families with children requesting emergency shelter increased between 1985 and 1986. The increases ranged from 46% in Louisville, 40% in Detroit, 30% in Los Angeles and Seattle, and 20% in New York City, Norfolk, San Francisco and Trenton, to 5% in San Antonio. (U.S.C.M, 1986)

* Families with children comprise 76% of the homeless population in New York City, 52% in Portland, 50% in Philadelphia, Trenton and Yonkers, 40% in Chicago and Kansas City, and 35% in Seattle. Families comprise 20% or more of the homeless population in Boston, Cleveland, Denver, Phoenix, Salt Lake City, and San Francisco. (U.S.C.M, 1986)

* In the first 8 months of 1984, suburban Nassau County, Long Island, one of the wealthiest communities in the nation, housed 724 homeless families. Neighboring Suffolk County served 919 families just in the first 6 months of 1986. (Brandwein, 1986)

SHELTERS FOR FAMILIES VERY LIMITED

* Emergency shelters able to serve families are particularly lacking in 70% of the surveyed cities including Chicago, Cleveland, Denver, Detroit, Louisville, Phoenix, Seattle, Philadelphia, Portland, and Los Angeles. (U.S.C.M., 1986).

* The existing shelter in New York City consists mainly of congregate, barrack-style shelters and single-room occupancy hotels which are inadequate to meet the needs of the 15,000 family members, including 10,000 children currently in need of emergency shelter in New York. (Committee on Government Operations [Gov. Ops.], House of Representatives, 1986)

* The estimated number of homeless families in Massachusetts ranges from 600-2,000. On any given night, the maximum capacity family shelters can serve is approximately 200 families. Presently 425-450 families are housed by the state in hotels and motels. (Gallagher, 1986)

* A Los Angeles County, California, shelter with room for 6 families receives more than 150 calls from homeless families each week; another Los Angeles shelter which can

house 2 or 3 families receives 40-50 calls per day. In Alameda County, shelter operators have stated that in a given week they receive requests for 3 times as many beds as they have available. In Sonoma County, fewer than half of the homeless families can be accommodated. (Roberts and Henry, 1986)

CHILDREN AND TEEN PARENTS ACCOUNT FOR SIGNIFICANT PORTION OF THE HOMELESS

* Nearly 50% of the homeless parents seeking shelter during 1985 in Boston were between the ages of 17 and 25 years. (The Emergency Shelter Commission [ESC] and the United Community Planning Corporation [UCPC], Boston, April, 1986)

* This winter, 20% of the families admitted to a San Antonio shelter were headed by teen parents. 14% of those admitted were under 21. (San Antonio Metropolitan Ministry Shelter, San Antonio, Texas, 1987)

* In Boston, nearly half (46.5%) of the children in family shelters were under five years old, and of these 13.2% were infants under one. School-age children comprised the remaining 53.5%; ages 12-17 years old comprised 11.7%. (ESC and UCPC, 1986)

LIMITED AFFORDABLE HOUSING, INSUFFICIENT AFDC GRANTS CONTRIBUTE TO FAMILY HOMELESSNESS

* Families are a large percentage of the 2-1/2 million people who are displaced from their homes every year as a result of eviction, revitalization projects, economic development plans and spiraling rent inflation. 1/2 million low rent dwellings continue to be lost each year as a result of condominium conversions, abandonment, arson and demolition. (Gov. Ops., 1986)

* Nationally, it has been estimated that by 1985 there were twice as many low-income households as there were low-cost housing units; in California, the ratio of low-income households to low-cost housing units in 1985 was 4 to 1. (National Low-Income Housing Coalition, 1986; McChesney, 1987)

* Between 1970 and 1980, available housing in Detroit decreased by 11% or by 58,696 units, more than in any other U.S. city. (Michigan Housing Coalition, 1985)

* Aid to Families with Dependent Children (AFDC) is the primary source of income for over 80% of homeless families in Boston; the current monthly benefit for an AFDC family of 3 is about $575, less than the least expensive two bedroom apartment listed in Dorchester, Massachusetts (Boston neighborhood) in Fall, 1985. (ESC and UCPC, Boston, April, 1986)

* In Michigan, the highest possible AFDC shelter allowance is only 45% of fair market rent value. In California, the 1985 monthly AFDC benefit for a mother with one child is $448, compared to $491, the median rent for a one bedroom

apartment in Los Angeles. (Michigan Task Force on the Homeless, March, 1986; McChesney, 1987)

HOMELESS FAMILIES ARE SHELTERED IN UNSAFE AND INADEQUATE SETTINGS

- * Many shelters and hotels used as emergency shelters for homeless families with children are located in dangerous neighborhoods, where criminal activity such as prostitution and illegal drug dealing is not uncommon. (Gov. Ops., 1986)

- * The Legal Aid Society of New York found that homeless families in one shelter had been exposed to lead and asbestos contamination. At one hotel in New York City, officials found nearly 1,000 violations of health, building and housing codes. (Gov. Ops., 1986)

- * The motels in suburban Suffolk County, Long Island, used to house homeless families, provide no telephones in the rooms, and no daily housekeeping services. Families are crowded in one room, with no playground for the children; few kitchen facilities; often isolated from friends and family; without a car or public transportation; and with their children exposed to motel residents who may be transients, prosititutes, or substance abusers. (Brandwein, 1986)

- * In New York, 70% of families living in hotel shelters lacked refrigerators and had no cooking facilities. The majority of hotel families eat cold food in their rooms chilled in coolers, toilet tanks or sinks. (Citizen's Committee for Children of New York, 1984)

- * In 1985, about 1/3 of the sick infants in New York City's single-room occupancy hotels were without cribs in their rooms. (National Coalition for the Homeless, 1985)

HOMELESS INFANTS AND CHILDREN SUFFER SERIOUS HEALTH CONSEQUENCES; SOME HAVE DIED

- * 7 of the 89 child abuse-related fatalities in New York City in 1985 were children living in welfare hotels. (Human Resources Administration, Public Child Fatality Review Committee Report, New York, December, 1986)

- * During 1982 and 1983, the proportion of low birthweight babies (under 2500 gms.) born to pregnant women living in 10 New York City hotels for the homeless was more than twice as high (18.0%) as for women in the city as a whole (8.5%). Over half of the homeless women had minimal or no prenatal care. (New York City Department of Health, 1984)

- * Between Spring, 1985 and December, 1986, the rate of chronic health conditions among the 1,028 homeless children seen in health programs nationally was 16%, nearly twice the rate observed among ambulatory children in general. (Wright, 1987)

- * Gastroenteritis, often caused by the ingestion of harmful bacteria from stale infant formula and unsterilized bottles, is one of the most common reasons for homeless infants being admitted to hospitals. Other serious complications such as weight loss, infected diaper rashes, and staph infections among infants are also requiring expensive medical care and follow-up. (National Coalition for the Homeless, 1985)

DEVELOPMENTAL DELAYS, ACADEMIC AND EMOTIONAL PROBLEMS AFFECTING EDUCATIONAL PROGRESS FOR HOMELESS CHILDREN

* In one study of homeless children in Massachusetts, developmental delays were present in 47% of the children aged 5 years or younger, and 33% had 2 or more developmental lags. These included dependent behavior, aggression, shortened attention span, withdrawal and demanding behavior. They also exhibited problems with sleep, coordination, fear of new things, and speech difficulties. (Bassuk, 1986)

* In St. Louis, homeless children are displaying cognitive and developmental problems at three times that of the general child population. When tested, 80% of the children displayed significant language deprivation, an important predictor of school success. (Whitman, 1987)

* In a study of homeless children ages 6 to 11 residing in Massachusetts shelters, 66% of the boys and almost 50% of the girls required further psychiatric and medical evaluation. 51% of the children older than 5 were depressed and most stated that they had suicidal thoughts. (Bassuk, 1986)

* In addition to irregular school attendance, parents reported that almost 25% of the homeless children in Massachusetts were failing or performing below average; 25% were in special classes; and 43% had already repeated one grade. 60% of homeless children studied exhibited high levels of anxiety and depression which interferred with their capacity to learn. (Bassuk, 1986)

2/24/87

SUMMARY OF FULL COMMITTEE HEARING ON "CHILD ABUSE AND NEGLECT IN AMERICA: THE PROBLEM AND THE RESPONSE" WASHINGTON, D.C., MARCH 3, 1987

Continuing its examination of the ongoing problem of child abuse, child sexual abuse, and other family violence, the Select Committee on Children, Youth, and Families held a hearing on March 3, 1987, on "Child Abuse in America: The Problem and the Response."

At the hearing, the Committee also released its report, Abused Children in America: Victims of Official Neglect. The report is based on a survey of the Governors regarding governmental and private activities to prevent and address child abuse and neglect in their states. The report documents the large increases in reports of child abuse and neglect over the past 5 years, as well as the failure to provide adequate resources to address the problem of child maltreatment, or underlying causes.

The first witness was Dr. Richard Krugman, M.D., Director, C. Henry Kempe National Center for the Prevention and Treatment of Child Abuse and Neglect; Associate Professor and Vice Chairman of the Department of Pediatrics, University of Colorado School of Medicine; and Chairman, American Academy of Pediatrics, Task Force on Child Abuse and Neglect, Denver, CO. Dr. Krugman discussed both adverse trends and positive trends in the field of child maltreatment. He said adverse trends include the continued rise in child abuse reports, fueled by sexual abuse, increases in abuse-related child fatalities, and an increased criminalization of the child protection process. He said that positive trends included a surge in professional recognition of child maltreatment and a willingness to report, especially among physicians. He also credited the establishment of Children's Trust Funds in 38 States to address child abuse prevention, and better federal leadership in the past two years by the National Center on Child Abuse and Neglect.

Dr. Krugman also discussed preliminary findings from the KEEPSAFE PROJECT, a therapeutic preschool for maltreated children, which has saved the Denver school system $10,000 per child in special education costs, and a child abuse prevention initiative in Denver area hospitals, which provides supportive in-home services to parents of newborns.

The Committee heard next from Frederick Green, M.D., President of the National Committee for the Prevention of Child Abuse (NCPCA), Washington, DC. Dr. Green presented the major findings of NCPCA's recent telephone survey of state child protection agencies. According to the NCPCA survey, child abuse reports increased 6% between 1985-86, declining slightly from the 10% increase between 1984-85; abuse-related child fatalities had increased fully 29% between 1985-86. Green stated further that many of the children who died had previously come to the attention of child protection services, and speculated that the system may be too overburdened to respond appropriately and prevent serious injury or death.

Dr. Green expressed reservations about proposals to limit the child protection system to cases where harm has already occurred, or where behavior might have resulted in harm. He said this approach overlooks the fact that child abuse often progresses if not recognized and treated. He also stressed that although over 50% of child abuse and neglect reports are labeled "unsubstantiated" this does not mean these reports are "unfounded." He explained that overburdened child protection workers may categorize cases that are incompletely investigated as "unsubstantiated." Dr. Green said that many of these cases are eventually determined to be actual cases of child abuse or neglect and are re-categorized as substantiated.

Next Douglas Besharov, Resident Scholar, American Enterprise Institute, Washington, DC, told the Committee that a large number of reports of child maltreatment are investigated and determined to be "unfounded," or "unsubstantiated." He stated that these unfounded reports add unnecessary pressure to an already overburdened child protection system thereby increasing the chance that a truly serious case of child abuse will be overlooked. Mr. Besharov recommended that states be given incentives to develop and disseminate materials to educate the public about what constitutes a "reportable" case of child abuse or neglect, as well as incentives to adopt better screening procedures.

The Honorable Ruth Massinga, Secretary, Department of Human Resources, Baltimore, MD, testified next. She said that the State of Maryland is experiencing dramatic increases in reports -- a 27% increase in the past 18 months. She has continually added staff -- 55 additional staff in FY'86, 60 more in FY'87, and another 123 requested for FY'88 -- and is afraid even this will not be enough to keep up with projected increases. But Secretary Massinga said turnover is frequent among Child Protection Service (CPS) workers; it is difficult both to attract and retain well-trained and experienced staff due to long hours, low pay and stressful work that is often unappreciated.

Secretary Massinga recommended strengthening the intake process in CPS agencies by staffing intake positions with the best trained and most experienced workers and by providing them with tested risk assessment tools. She also stressed the importance of prevention programs for high risk families to prevent out-of-home placement of children and described two family strengthening and preservation programs that the State of Maryland is currently operating. The family preservation program has improved family functioning and reduced the need for costly out-of-home placement; the Family Support Centers, community-based drop-in centers that foster healthy development of children and help young parents develop good parenting skills, are currently being evaluated.

The Committee heard next from Jeanne Soulis, Research Coordinator, The Children's Place, Kansas City, MO. Ms. Soulis described her agency's day treatment program for maltreated preschool children, which also provides services for parents. Children and their parents are tested before starting the day treatment program, and then at 3-4 month intervals. Most of the children are developmentally delayed by an average of 6 months; many of the mothers are also clinically depressed. After 9 months in the program -- the average length of treatment -- most of the children have progressed developmentally to a normal level, thus allowing them to avoid special education programs, and attend regular kindergarten and first grade classes. The mothers also show progress in ameliorating their depression.

Despite its demonstrated success, The Children's Place day treatment program last year served only 83 families out of the 1500 families with children under 5 identified as needing the program's services.

The last witness to testify was Pat Raphael, President of Massachusetts Parents Anonymous, Boston, MA. Ms. Raphael described her personal experience as a child abusing parent who was helped by Parents Anonymous and eventually became president of its Massachusetts chapter. She said the current child protection system does not respond to a potentially abusing parent and stressed the need for prevention programs that encourage both abusing parents, and parents who are afraid they will abuse their children, to reach out for help. She recommended federal support for early intervention services and continuing federal support for Parents Anonymous, as well as assistance for other self-help programs and public awareness efforts.

ABUSED CHILDREN IN AMERICA: VICTIMS OF OFFICIAL NEGLECT

A Report of the

Select Committee on Children, Youth, and Families

FINDINGS

REPORTS OF CHILD ABUSE, PARTICULARLY SEXUAL ABUSE, ON RISE

- In a survey of the 50 states and the District of Columbia, between 1981-85, the number of children reported to have been abused or neglected rose 54.9%. Between 1984 and 1985 alone, child abuse reports increased nearly 9%. In addition, many states reported increasingly more serious and complex cases.
- Among the three major child maltreatment categories, physical abuse, sexual abuse, and neglect, reports of sexual abuse rose the fastest. For the 29 states providing complete information, sexual abuse increased 57.4% between 1983-84, and increased 23.6% between 1984-85.

REPORTS OF CHILD NEGLECT CONTINUE TO INCREASE

- Child neglect continues to represent the majority of maltreatment cases (58.5% in 1985). States providing information by type of maltreatment report a continuing increase in the number of children reported to have been neglected between 1981-85. For 1984-85 alone, these states report an overall increase of 5%.
- Despite the large number of child neglect cases, several states indicate growing inattention to neglected children over the past decade as reports of sexual abuse have increased.

DESPITE INCREASED REPORTS OF CHILD ABUSE, STATES UNABLE TO PROVIDE NEEDED SERVICES

- A majority of states report staff shortages, inadequate training, high personnel turnover, and a lack of resources for staffing as the principal barriers to improved child protection and child welfare services.
- For the 31 states able to provide complete information, total resources to serve abused and neglected children increased, in real terms, by less than 2% between 1981 and 1985.
- In 27 of these states, resources to serve abused and neglected children declined in real terms, or failed to keep pace with rapidly increasing reports of child abuse. Between 1981 and 1985, states lost more than $170 million, in real terms, in Social Services Block Grant (Title XX) funds alone; for 27 states, Title XX was the largest source of federal funds, and for 15 of them, the largest single source of funds -- federal, state or local -- for providing services to abused and neglected children and their families.

- While child protection and child welfare services require the coordination of many agencies, including social services, health, education, and law enforcement, several states indicate that difficulty in coordinating these efforts is a barrier to better services for children.

STATES CITE TWO PRINCIPAL FACTORS LEADING TO INCREASED CHILD ABUSE REPORTS

- Nearly every state ranked public awareness as a primary factor resulting in increased reports of child abuse and neglect.

- 60% of the states ranked deteriorating economic conditions for families as another primary factor resulting in rising reports of child abuse and neglect.

PREVENTION RECEIVING INCREASED ATTENTION; STATES EMPHASIZING FAMILY-BASED SERVICES TO PREVENT UNNECESSARY PLACEMENT OF CHILDREN OUT-OF-HOME

- Expenditures for public awareness of child abuse and neglect have risen in 27 states. 38 states have recently established Children's Trust Funds to support prevention programs. Nearly 1/2 of the states offer parent education, while at least 15 states provide prenatal and perinatal services to high risk women and teenagers and their infants. In addition, several states provide preventive programs of respite care, crisis nurseries, and early screening for developmental disabilities, for some portion of the population.

- Citing the need for permanency in children's lives and dwindling resources available to aid abused children, states are increasingly providing services to strengthen and maintain families. Homemaker and parent aide services received higher funding in 22 and 17 States, respectively. 18 states reported that they are providing family preservation services.

COST-EFFECTIVE PROGRAMS PREVENT OR REDUCE CHILD ABUSE AND NEGLECT, STRENGTHEN FAMILIES AND REDUCE DEPENDENCY

- In addition to the many promising prevention programs, states identified 19 programs which, according to evaluations, have successfully prevented child abuse, improved family functioning, and avoided costly treatment.

- In addition to the many promising treatment programs, states identified 15 treatment programs which, according to evaluations, have reduced recidivism, enhanced parent-child interaction and prevented placement of children in foster care.

STATES LACK SUFFICIENT LAW ENFORCEMENT DATA AND INFORMATION ABOUT HOW FUNDS FOR CHILD ABUSE SERVICES WERE SPENT

- While nearly all states report involvement of Child Protective Services with law enforcement agencies, they cannot report the rate of indictment, prosecution and/or convictions related to child abuse and neglect, nor are they able to report the percent of substantiated cases of abuse and neglect which are referred to law enforcement authorities.

- Most states were unable to report what federal, state, or local resources they dedicated to six major services commonly provided to abused children, or children at risk of abuse. These services include: case investigation and assessment, substitute care, adoption services, casework and treatment services, child care, and staff training and education. In addition, the vast majority of states were unable to identify the number of children provided with each service.

3/87

SUMMARY OF HEARING ON "CHILD CARE: KEY TO EMPLOYMENT IN A CHANGING ECONOMY" WASHINGTON, D.C., MARCH 10, 1987

The Select Committee on Children, Youth, and Families held a hearing to assess the changing nature of the economy and the growing necessity for families to participate in the workforce. The hearing explored the importance of child care to families' ability to become and remain self-sufficient, and to improve employee productivity in the workplace.

The first panel began with testimony from Annie Bridgers, a single mother of three young children, Washington, DC, who said that without child care, she would not have been able to participate in the District of Columbia's Jobs Opportunity and Business Training program, which led to her employment as a receptionist. She indicated as well that she would be unable to retain her job without child care assistance, available on a sliding fee scale basis. Without her child care subsidy, she would be forced to rely on public assistance again. The full fee for child care for just one of her children would be nearly one third of her take-home pay.

Terri Maniker, a single mother of one child, aged 7, of Bethesda, MD, told Members that divorce plunged her and her infant daughter into poverty. She recounted that subsidized child care enabled her to earn an undergraduate degree and to avoid reliance on public assistance, but during law school she had to work three jobs because publicly-supported child care was not available. Since most child care programs do not have extended hours, according to Maniker, she will not be able to accept a job in a law firm which requires long hours. She concluded that for the "many women who combine work and family, without day care centers, millions would be called 'welfare mothers,' [instead of] 'superwomen'."

Tom Glynn, Deputy Commissioner, Massachusetts Department of Welfare, testified that without its child care component, the Massachusetts' Employment and Training Program (ET) would not work. Women with children, especially young children, cannot participate in training or work without adequate child care. Glynn explained why the ET child care budget -- nearly half of the total -- is so high: 1) the program serves recipients of Aid to Families with Dependent Children, 60% of whom have at least one child under 6; 2) ET pays for up to one year of transitional child care after employment; 3) child care is expensive -- in Massachusetts, the average cost is more than $3,000 per child per year. However, Glynn reported that this investment has paid off. Since ET began, the AFDC caseload has declined 4.4%, the number of families who have been on AFDC for 5 years or more has declined 25%, saving $122 million in 1986 alone.

Ronnie Sanders, Director, Voucher Day Care, Massachusetts Department of Social Services, described in more detail the child care component of the ET/Choices program. In 1987, Massachusetts will spend about $74 million on contracted child care for approximately 17,000 children from low-income working families or in protective services. About $27 million will be used to provide child care through a voucher system for about 8,000 children whose parents participate in or complete the ET program.

According to Sanders, transitional child care assistance, available for up to 1 year after starting a job, is critical to a client's ability to remain self-sufficient. Without a child care subsidy, more than 1/3 of participants' income would go to child care, substantially diminishing the value of earned income.

When child care assistance is available, women with very young children are able to participate. In 1984, at the start of the ET program, only 18% of all ET participants had children under 6. In 1987, because of an expansion in child care funds, that percent rose to 41%. Although the number of licensed child care providers doubled as the voucher program expanded, with much of the growth among family day care providers who became licensed in order to participate, Sanders pointed out that infant/toddler care remains in short supply.

The Committee then heard from Sue Miles, Coordinator, Early Childhood Education Program, Waubonsee College, Sugar Grove, IL. The campus child care center run by Miles serves children 16 months to 5 years whose mothers attend the 2 year college. It is funded through Title XX and the United Way, and operates on a sliding fee scale. Miles stressed that child care permits parents to complete a needed education and to work, promoting family self-sufficiency. According to Miles, such care improves children's school achievement, reduces delinquency and the need for special education, and increases work productivity in adulthood.

The Hon. Sunne McPeak, Chair, County Board of Supervisors, Contra Costa County, CA, cited changes in the economy, workforce, population of young children, and composition of families as factors responsible for the growing child care demand in Contra Costa County, which she described as a microcosm of California. In California, there are only 600,000 licensed spaces for the 1.6 million children under 15 who need care; in the County, according to McPeak, more than 25,000 children are underserved by the existing child care delivery system, and the greatest demand is for infant and school-aged child care.

McPeak described the county's role in meeting the child care need, including its responsibility for implementing the child care component of GAIN, California's welfare reform program. McPeak stressed, however, that state resources to implement GAIN are insufficient. Unless the county helps develop new child care resources, it will be impossible to serve all potential GAIN participants.

Calling for aggressive action to bolster the development of public-private partnerships, McPeak recommended that Congress support (1) seed money for community-based, public-private partnerships for child care; (2) tax credits for employers and developers to contribute to child care; and (3) tax credits for parents on a sliding fee scale basis so that lower income, working parents are the primary beneficiaries of this policy.

Richard Vicars, Vice President of Human Resources, Lincoln National Life Insurance Corporation, Ft. Wayne, IN, attested to the need to accommodate the increasing number of employees who are single parents or dual wage earners, as well as children's need for a healthy environment in which to develop. To address these needs, his company designed an exemplary benefits package which includes an in-house child care information and referral service, flexible work scheduling, a tax exempt salary reduction plan for dependent care, and a contract with a local hospital for sick child care. According to Vicars, high quality child care benefits employers as well as children and their families.

Philip K. Robins, Ph.D., Professor of Economics, University of Miami, FL, reviewed the results of his research on the role of child care in promoting economic self-sufficiency among low income families residing in public housing. Based on an extensive survey, he found that an increase in the availability of child care within a public housing site causes a corresponding increase in positive work outcomes for residents. For example, a 50% increase in the size of an onsite child care center would result in a 19.5% increase in residents' earnings, a 13.5% increase in hours worked, and a 4% decline in average welfare benefits. Based on resident parents' indication of need, however, Robins found that there was a waiting list of 96,000 children nationwide in need of child care in public housing.

Another study of his found that the higher the cost of child care, the less able mothers are to enter the workforce. According to Robins, these findings suggest that government efforts to subsidize child care costs or to increase availability would lead to a significant increase in the economic well-being of families.

Harry L. Freeman, Executive Vice President, American Express Company, submitted testimony on the role of the corporation in child care. Freeman emphasized that child care is closely linked to worker productivity and company profitability. Problems with child care arrangements cost employers an average of 8 worker days every year for each employee with a child under age 13.

Since 1984, American Express has provided a child care referral program for its 12,000 New York City employees, and is expected to expand these services to 33,000 employees at all major U.S. locations, and to assist in the development of family day care networks for the benefit of communities across the country. American Express also offers a tax-exempt dependent care account, and an employee assistance program that includes seminars and counseling on work and family issues.

Recognizing that the need for child care has reached crisis proportions, Freeman pointed out that corporations have an obligation to their communities to ensure quality, licensed child care. In addition, he stressed that the private sector must operate in partnership with the public sector to improve the quality and supply of child care. He urged federal and state leadership in this endeavor.

CHILD CARE: KEY TO EMPLOYMENT IN A CHANGING ECONOMY

FACT SHEET

LACK OF CHILD CARE IS BARRIER TO EMPLOYMENT

- 36% of mothers in families with incomes less than $15,000 per year said they would look for work if child care were available at a reasonable cost. Single mothers were twice as likely to respond in this manner (45%) than married mothers (22%). (Census, 1983)

- 1/3 of nonworking mothers with preschool children who dropped out of high school said that they would look for work if they had reasonably priced child care. (O'Connell and Bloom, 1987)

- In a survey of 1,200 California parents, 1/4 of all homemakers and unemployed parents, including 1/3 of all single parents, reported that inadequate child care arrangements kept them from working or attending training programs. (California Governor's Task Force on Child Care, 1986)

- Of 130,000 Philadelphia County, Pennsylvania families, 1 out of 5 reported lack of child care as a major deterrent to employment. (Fernandez, 1986)

- Nearly 2/3 of the single mothers receiving AFDC benefits surveyed in Washington State cited difficulty with child care responsibilities as a primary problem in seeking and keeping jobs. More than 3/4 of the women who had stopped looking for work cited child care difficulties as preventing their search for, or attainment of, employment. (National Social Science and Law Center, 1986)

CHILD CARE BENEFITS IN THE WORKPLACE: LIMITED, BUT GROWING

- Of 8,121 employees in Portland, Oregon, 47% of female employees and 28% of male employees with children under age 12 reported stress due to their child care arrangements. (Galinsky and Friedman, Investing in Quality Child Care: A Report for AT&T, [AT&T], 1986)

- Of 5,000 workers at 5 corporations in the Midwest, 58% of the female workers and 33% of the male workers with young children felt that their child care concerns affected their time at work in unproductive ways. (AT&T, 1986)

- In 1985, only 1% of employees in medium and large firms were eligible for even partial defrayment of costs associated with day care for their children. (O'Connell and Bloom, 1987)

- Between 1970 and 1986, the number of employers providing child care services for children of their employees rose from under 50 to about 2000. But they represent few of the nation's 6 million employers or the 44,000 companies with 100 or more employees. (O'Connell and Bloom, 1987)

- In a representative study of 600 adults in U.S. households with incomes of at least $25,000, 80% said they want employers to offer child care referral services; 70% want employer-provided on-site child care, and 58% would like subsidized child care. Among the 21% of households with a child under age 6, 45% would consider changing jobs or returning to work if they knew of a company that provided flexible work hours. On-site child care and subsidized child care would encourage 39% and 34% respectively to change jobs or return to work. (LAR/Decision Research, 1987)

CHILD CARE PROVIDES WAY OUT OF POVERTY FOR LOW INCOME PARENTS

* Almost 1/2 of the participants in a voucher day care program in Massachusetts were able to terminate AFDC. Employment levels rose with the length of participation, from 63% at baseline to 93% for those using the child care vouchers for 12 months or more. Among individuals looking for work, 70% found employment. (Grey, et al, 1984)

* Child care offered on a sliding fee scale basis in Florida resulted in a 50% reduction in welfare recipiency, a 123% improvement in employment, and a 117% increase in family income. Once AFDC recipients left welfare, they remained self-sufficient. (Hosni and Donnan, 1979).

* Family income and taxes paid increased 6-1/2 times among California families who used a child care program for two years. Total public funding was offset by 45% and 68% of AFDC families no longer required income assistance. (Freis and Miller, 1981)

* Child care provided on-site at a St. Paul high school has been a major factor in allowing 80% of teen mothers to complete high school. Programs in selected Mississippi schools which offer child care also show a 90% high school graduation rate among teen mothers. (Select Committee on Children, Youth, and Families [CYF], 1984)

LACK OF CHILD CARE PERSISTS DESPITE GROWING NEED

* In FY 1986, states' overall Title XX Social Services Block Grant (SSBG) expenditures for child care were approximately 12% lower -- in constant dollars -- than in 1981. In FY'86, 23 states were providing fewer children with child care assistance through the Title XX SSBG than they did in 1981. Only 15 states were serving more children. Between FY'85 and FY'86, 11 states again reduced the number of children served in their Title XX funded child care programs -- almost twice the number of states that reduced children served between FY'84 and FY'85. (Children's Defense Fund, State Child Care Fact Book, 1986)

* While low income, female-headed households account for 80-90% of the families receiving child care subsidies through some combination of federal, state, and local funds, many states are serving less than 30% of their eligible population. (Marx, 1/87)

* Only 7% of the estimated 1.1 million California children are eligible for subsidized child care. California provides state funds for 63,000 children ages 0-14 in child

care programs, and for 20,000 children in State preschool programs. (California Assembly Office of Research, 1986)

- In New York, between 830,000 and 1.2 million preschool and school-age children need child care, in contrast to the fewer than 135,000 licensed child care placements that are available statewide. (New York Commission on Child Care, 1987)
- In one representative area of Houston served by the Urban Affairs Corporation, 92 infants are enrolled in day care to allow their teenage mothers to complete school or work; 90 additional infants are on a waiting list. (Bryant, 1987)
- In more than 230 public housing projects with child care centers recently surveyed, there was a waiting list of approximately 96,000 children. (Robins, 1987)

MORE WOMEN IN WORKFORCE

- Since the mid-1960's, the number of women in the workforce has more than doubled. Currently, 54.5% of women are active in the workforce. More than 62% of all new jobs created since the mid-1970's went to women, and more than 60% of all working women are employed in clerical, sales, and service sector occupations. (Sacks, 1986).
- Women will account for the majority of the labor force growth from 1984 to 1995. In 1970, 50% of women between age 25 and 44 were in the workforce; by 1995, it is estimated that more than 80% of these women will be working. (Department of Labor, 1986)
- Currently, 70% of all women in the workforce are of child-bearing age; 80% of them are expected to become pregnant sometime during their work careers. (AT&T, 1986)

MORE MOTHERS IN LABOR FORCE

- Half of all married mothers with infants under age one are in the workforce -- a 108% increase since 1970. (Bureau of Labor Statistics [BLS], 1986)
- In 1986, 60% of mothers whose youngest child was 3-5 years old were employed -- up from 45% a decade earlier. (BLS, 1986)
- The 1990's will be the first decade to begin with a majority (55%) of married mothers of children under age 6 in the labor force, an 80% increase since 1970. (CYF, 1984)
- In 1985, 67.8% of single parent mothers worked, up from 59.7% in 1973. (Joint Economic Committee [JEC], 1986)
- By 1995, 2/3 of all preschool children (14.6 million) will have mothers in the workforce. Four out of 5 children between the ages of 7 and 18 are expected to have working mothers. (National Institute of Child Health and Human Development, 1986; Marx, 1987)

MORE MOTHERS WORKING FULL-TIME

- Of all mothers who worked in 1985, approximately 70% worked full-time. In 1985, 84% of black working mothers, 69% of white working mothers, and 79% of Hispanic working mothers worked full-time. (BLS, 1985; Hayghe, 1986)

- More than 2/3 of all employed mothers with preschool children work full-time. (BLS, 1986)

- 35% of women working part-time or looking for work would work additional hours if they could find affordable day care. (National Association of Working Women, 1986)

WOMEN MAKE CRITICAL CONTRIBUTION TO FAMILY INCOME

- In two-parent households, real income declined 3.1% between 1973 and 1984, but would have declined by 10% were it not for the increased number of working mothers. (JEC, 1986)

- In a 1983 New York Times survey, more than 71% of working mothers with children said they work to support their families. (JEC, 1986)

- One fourth of working women earn more than their husbands. In addition, 25% of working women are married to men who earn less than $10,000/year; 50% are married to men who earn less than $20,000/year and 80% of working women are married to men who earn less than $30,000/year. (AT&T, 1986)

- Between 1967 and 1985, wives' contributions to family income increased from 10.6% to 18.0% for white families with children, from 19.4% to 30.4% for black families with children and from 14.4% to 20.0% for Hispanic families with children. On the average, in 1985, the earnings of two-parent families were 24.4% higher than they would have been had wives not worked and had all other income sources remained at their 1985 levels. (JEC, 1986)

3/10/87

SUMMARY OF JOINT HEARING ON "CATASTROPHIC HEALTH INSURANCE: THE NEEDS OF CHILDREN" WASHINGTON, D.C., MARCH 23, 1987

The Select Committee on Children, Youth, and Families held a joint hearing with the Select Committee on Aging, Subcommittee on Health and Long-term Care, to explore the catastrophic health needs of America's children. The hearing examined catastrophic and long-term health care needs of children, including new findings on the cost of medical and home health care and the availability of insurance.

Susan Sullivan, actor, from Los Angeles, CA; and member, Board of Trustees and spokesperson for the Foundation for Hospice and Home Care, Washington, DC, testified that the cost of home care for chronically ill children is about one fourth that of institutional care. Ms. Sullivan stressed that long-term care must be part of a coordinated effort that is flexible enough to adapt to each family's situation and comprehensive enough to provide home care for children with catastrophic illnesses.

Randy Kramer, age 25, from Miami, FL, with cystic fibrosis, spoke of her difficulties in obtaining home care benefits from her private insurance company, and since age 22, from Medicare. Randy stated that Medicare will not pay for her therapy at home because she does not meet the criteria for being homebound. The annual cost of her health care is $100,000, an amount which could be substantially reduced if Medicare reimbursed care provided at home.

Angie Bachschmidt, Washington, DC, spoke of the ventilator care needed by her 4 year old son, Robert, who has muscular dystrophy. Because payment for home care was so difficult to obtain, Robert stayed for 18 months in Children's Hospital at a cost of $865,800. Home care for the same period could have been provided for $90,000, one-tenth of the cost. Since January, 1985, Robert has lived at home, and his medical care has been paid by Medicaid. However, Bachschmidt stated that Robert's need for physical, occupational and speech therapy remains unmet because these services are not covered by Medicaid or CHAMPUS, for which he is also eligible due to his parents' military affiliation.

Mr. and Mrs. Tracy Sutton, parents of Alex Sutton, age 3, with Tay-Sachs disease, from Phoenix, AZ, testified about Alex's degenerative, terminal illness which requires a complicated regimen of medications and care. After a long battle with their private insurance company to cover Alex's home care, they secured coverage of 80% of the $200,000-250,000 in annual costs; the remaining 20% that the family must pay is still burdensome. Alex's father stated that dealing with catastrophic illness, such as Tay-Sachs, is emotionally stressful for families, and called for a policy to ease families' financial burdens.

Sandy Reckeweg, parent of Jeffrey, age 5, from Clinton, MD, also testified. Jeffrey has Ondines, a breathing disorder. Reckeweg stated that most of Jeffrey's life was spent in the hospital until provisions could be made to use a respirator at home. She also testified that Jeffrey's care cost $600,000 a year for hospital care, and $150,000 for home care. Jeffrey's private insurance policy, which includes a cap of $100,000, was exhausted in less than 9 months; since then the family has incurred a debt of $800,000. Reckeweg said that because technology is keeping many children alive, society owes them a catastrophic health care program which will give children the right to be cared for at home.

Joe Miller, age 18, from Los Angeles, CA, became paralyzed after a bicycle accident in 1985. Since he was discharged after a 7 month hospital stay, his medical benefits have been limited. While his parents' employer-based insurance covered much of his medical care, Miller testified that his mother was forced to quit her job to care for him at home, and consequently her policy will soon lapse. Still, his home care costs $500 to $1000 a month compared to $18,000 per month in the hospital. He concluded that unless some change is made in government policy to help with the costs of catastrophic illness, he will have to face very high bills for the rest of his life.

Steven Brown, age 22, from Bethesda, MD, was accompanied by his mother Diane Fleming. Steven has Duchenne's muscular dystrophy, a disease that gradually weakens the body's muscles. He related that, when his condition became life-threatening in 1984, he chose to have a tracheostomy and to live with a ventilator in order to survive. He has been living at home for 2-1/2 years, at a cost of about $17,000 per month compared to $46,000 per month for hospitalization. Maryland Medicaid covers some of the expenses, as does the Muscular Dystrophy Association. Still many services are not covered, and the family has experienced a great deal of stress. Fleming closed her testimony by stating that, without comprehensive care, technology-dependent children do not experience the quality of life to which they are entitled and urged enactment of legislation to ensure that all children who need home care receive it.

Daniel Russell, age 4, of Kalamazoo, MI, was accompanied by his mother, Mrs. Scott Russell. Daniel, a premature infant, remained hospitalized after his birth with breathing problems caused by a weak congenital area in his trachea. A tracheostomy was performed to stabilize his breathing and at 7 months of age he was discharged home. Hospital bills covered by insurance were $1,000 a day, totaling almost 1/2 million dollars by the time he was discharged. The cost of home care for Daniel is under $200 a day, but insurance covers only 75% of the cost. Russell concluded that leaving her child in a hospital, where the costs are reimbursed, or bringing him home, where out-of-pocket expenses are four times her income, is a choice most families of technology-dependent children could not afford to make.

Robert K. Massie Jr., age 30, from Boston, MA, has hemophilia. He described how the high cost of his care during childhood posed difficulties for his family who were in the military. During one tour of duty, the French National Health Insurance system relieved his family of health care costs for the first time. Due to recent scientific advancements, Massie now can self-administer anti-coagulant treatments at an annual cost of approximately $5,000. This home-based treatment allows him to lead a normal life, previously as a chaplain at Yale New Haven Hospital, and currently as an activist on behalf of chronically ill children.

Honorable Frank Moss, former U.S. Senator; and Chairman, Board of Trustees, Foundation for Hospice and Home Care, Washington, DC, testified that there are 10 to 12 million children who suffer with some degree of chronic health problem, with 2 million suffering severe chronic illness. Several million more children have experienced accidental injury. It is the evolution and refinement of technology which has made it possible for these children to be cared for at home, but according to Senator Moss, U.S. policy has not kept pace with technology. Many children are needlessly institutionalized. In conclusion, Senator Moss stated that there is universal agreement that the nation needs to enact a catastrophic health program, one that would address the major gap in long-term care for children.

Honorable Charles Percy, former U.S. Senator; and Vice Chairman, Board of Trustees, Foundation for Hospice and Home Care, Washington, DC, concurred that thousands of children remain in hospitals and other institutions because bureaucratic programs present barriers to home care. He shared the major findings of the Foundation's report, including that physicians generally agree that it is possible to manage the care of most chronically ill children at home, and agree on the criteria which must be met for hospital discharge; that most families do not abandon children born with anomalies and want them home; and that the major factor which stands in the way of bringing most children home is lack of funding. The Foundation's recommendations underscored the need to make changes in public and private funding sources to coordinate home care services for medically fragile children.

James Perrin, M.D., Director, Ambulatory Care Programs, Children's Service, Massachusetts General Hospital, Boston, testified on behalf of the American Academy of Pediatrics. Perrin reported that fewer than one million children (1% of all children under 21) are likely to incur catastrophic expenses, but families who experience a catastrophic illness -- at birth, in childhood, and/or in adolescence -- are often placed in extreme financial indebtedness. Perrin included recommendations to reduce the family's, provider's and insurer's risk in caring for children with catastrophic illness: state-mandated high risk pools, employee mandates covering prenatal and primary services for children, Medicaid expansions, and expanded Title V Maternal and Child Health-Crippled Children programs. Each option, he cautioned, has limitations and needs to be examined in light of children's unique needs.

In conclusion, Perrin said that children with long-term illnesses and their families need access to at least six major services: high quality medical and surgical speciality care; high quality general pediatric or general health services, including immunizations and health supervision; nursing services to help children stay at home, be at home, and to receive care primarily from their families; preventive mental health services; and social services and educational services so that these children can survive well with their classmates in school.

J.D. Northway, M.D., President and Chief Executive Officer, Valley Children's Hospital, Fresno, CA, testified on behalf of Western Association of Children's Hospitals. According to Northway, 19%, or 10.2 million, of this nation's children aged 0-16 have no health insurance at all, and many of these uninsured are children of the "working poor." He cited recent survey findings that many families do not have access to group health insurance because the employer does not offer it or the coverage is prohibitively expensive. Other children have pre-existing medical conditions, such as cancer or cystic fibrosis, which prevent them from obtaining private insurance coverage.

Northway reported new data from California on the cost of child hospitalizations. During 1984, there were 553,000 children age 0-14 hospitalized in California, excluding mental health admissions and Kaiser Hospital admissions. Only 1/2 of 1% incurred charges in excess of $50,000, for a total cost of $280 million or 22% of the total charges incurred by all 553,000 admissions. If the cost was spread out over the entire population ages 0-14, the cost would be $4.55 per child per month, less than 1/3 the cost of providing one day of public school instruction for one child in California. To the extent that public resources fall short, Northway reported, the burden of catastrophic costs falls on tertiary institutions such as children's hospitals and university medical centers.

Josephine Gittler, J.D., Co-Director, National Maternal and Child Health Resource Center, University of Iowa, Iowa City, concurred that a significant portion of the child population under 18 years of age lack private or public health insurance coverage for all or part of the year, and that in recent years a growing number of children have become under-insured. Her preliminary data shows that hospital care for technology dependent children costs $24,800 to $34,000 per month, compared to monthly home care costs ranging from $5,500 to $9,000. Gitler described a number of federal initiatives that could reduce insurance problems among children who have catastrophic health expenditures, including: establishment of a federal catastrophic health insurance program through the Title V Program for Children with Special Health Care Needs; expansion of Medicaid program eligibility; state options allowing uninsured or underinsured families to purchase Medicaid benefits with an income-adjusted premium; creation of state high-risk pools to enable uninsurable children to obtain comprehensive health insurance at reasonable prices; and finally, mandating or offering incentives to employers for the extension of minimum health care benefits to their employees and the dependents of their employees.

Sara Rosenbaum, Director, Child Health, Children's Defense Fund, Washington, DC, testified that in 1984, nearly 1 in 5 children, and 1 in every 3 poor children, was uninsured. The two main causes are: the major gaps in employer-based health insurance; and the failure of Medicaid to compensate for these gaps. She stated that it is essential to increase the percentage of children with health insurance and that any catastrophic policy approach for children must address both their relative and absolute catastrophic needs. For the immediate future, she recommended expanding Medicaid to reach more poor children who have no insurance and the development of a supplemental funding program to aid families whose children have catastrophic health needs.

Constance U. Battle, M.D., Medical Director and Chief Executive Officer, The Hospital for Sick Children, Washington, DC, spoke on behalf of National Association of Children's Hospitals and Related Institutions (NACHRI). She was accompanied by Robert H. Sweeney M.D., President, National Association of Children's Hospitals and Related Institutions, Alexandria, VA.

Sweeney presented findings from a recent NACHRI study of 85,000 admissions to children's hospitals nationwide. While only

1.35% of these admissions had charges over $50,000, they accounted for 26% of the total charges for the children's hospitals. Of these cases, 50% were newborns. Sweeney summarized four components of a comprehensive solution for children: require employers to provide minimum insurance which covers prenatal services and primary services for children, with insurance pools to assist small employers; facilitate individual choice of basic and catastrophic coverage through state risk pools and tax incentives; mandate Medicaid coverage for pregnant women and children under age 6 who are below the federal poverty level, and standardize Medicaid coverage for mandated services; and include children and young adults in federal demonstration projects and studies of catastrophic insurance coverage.

Battle discussed the need for transitional care for infants from intensive care to their homes and communities. She presented case studies of children who survive today and are able to live with their families, but would not have in the past, illustrating clearly the changing technology and enhanced needs of a pediatric population in need of long-term. She concluded with the hope that creative and comprehensive programs can be developed to both care for these children and to provide stable financing for that care.

Michael Morris, Executive Director, United Cerebral Palsy Association (UCPA), who testified on behalf of the Consortium for Citizens with Developmental Disabilities, Washington, DC, shared findings from a UCPA survey which showed that the average expenditure per year for special disability-related expenses, excluding surgeries, was $5,282 per family. To raise a child to the age of 18, the cost would be $95,083. If surgeries are included, the cost increases to $7,035 per year, or $126,631 to age 18. Morris noted that, of their survey respondents, only 1% were able to bear the additional expense of supporting a disabled family member without outside help. He stated finally, that appropriate coverage options for children and adults must be developed to stem the rising tide of individuals who find themselves medically uninsurable.

CATASTROPHIC ILLNESS AND LONG-TERM CARE: ISSUES FOR CHILDREN AND FAMILIES

FACT SHEET

EXTENT OF CHRONIC ILLNESS AMONG CHILDREN

* Approximately 10 million children (10-15% of all children) have a chronic illness; about 1 million have a severe chronic illness. (Gortmaker and Sappenfield, 1984)

* Between 1960 and 1981, the prevalence of activity-limiting chronic conditions among children under age 17 doubled, from 1.8% to 3.8%. Respiratory conditions and mental and nervous system disorders demonstrated the largest changes. (Newacheck, Budetti, and Halfon, 1986)

* Prematurity is anticipated in 6 births per 1000; cystic fibrosis in 1 birth per 1000; congenital heart disease in 7.5 births; and a diagnosis of cancer in 130 children per 1 million. (National Association of Children's Hospitals and Related Institutions [NACHRI], 1986.)

* Prevalence rates of certain diagnostic groups may have increased as a result of improved chances for survival. The evidence suggests a sevenfold increase in survival to age 21 among children with cystic fibrosis, and increases of twofold or greater for children with spina bifida, leukemia, and congenital heart disease. In 1984, the survival rate for childhood cancer was over 54%, compared to 39% in 1970. (Gortmaker, 1985; American Cancer Society, 1984)

* Poor children are 40% more likely to have a severe functional disability than do children in families with higher incomes (8.5% vs. 4.9%). (NACHRI, 1986)

CHRONICALLY ILL CHILDREN HAVE HIGH MEDICAL COSTS

* The cost of care for very distressed, ventilator dependent infants who remain hospitalized can reach $350,000 per year. (NACHRI, 1986)

* The annual expenses for hospital and physician services for a child with a disabling chronic condition has been estimated to range from $870 to $10,229, depending on the severity of the illness. In contrast, the typical healthy child's expenses for these services average about $270 a year. (Fox, 1984)

* In 1980, more than $1.7 billion were expended for physician visits and hospitalization of children with activity limitations; hospitalization accounted for 65% of the total. The average annual hospital cost for a child with activity limitation was $511 compared with only $66 for a child without limitations. (Butler, et al, 1985)

* Comprehensive care for a child with cystic fibrosis can cost a family $6,000-12,000 annually; and intermittent hospitalizations may average over $7,000 per stay. (NACHRI, 1987)

- * Expenses for a child with cerebral palsy, including physician services, speech therapy, medications, special education, and other support services average $4490 annually, with 51% paid by the family. (United Cerebral Palsy Association, 1986)

ACUTE OR PRIMARY HEALTH CARE COSTS FOR CHILDREN HIGH

- * In 1985, newborn intensive care costs totaled $2.4-$3.3 billion and averaged $14,698 for each infant. (American Academy of Pediatrics [AAP], 1986)
- * Cardiac surgery for a child may cost a family $22,000 for a hospital stay. (NACHRI, 1987)
- * Treatment for extensive burns may result in a hospital bill of $45,000. (NACHRI, 1987)
- * The $600 cost of treatment for one asthma episode, or a routine hospitalization costing $700 per day, may be catastrophic for those with no insurance or very limited resources. (NACHRI, 1987)

SMALL PERCENTAGE OF CHRONICALLY ILL CHILDREN INCUR HIGH PERCENTAGE OF MEDICAL EXPENSES

- * Fewer than 1 million or 1% of all children under 21 are likely to incur catastrophic expenses if catastrophic is defined as out-of-pocket medical expenses greater than 10% of family income. (AAP, 1986; Newacheck, 1986)
- * About 5% of all children incur annual medical costs in excess of $5,000. Others estimate that 5-10% of children incur catastrophic expenses in excess of $10,000 (regardless of insurance coverage). (Rosenbaum, 1987; AAP, 1987)
- * In 1983-84, the 1.35% of admissions to children's hospitals incurring catastrophic expenses over $50,000 accounted for 26% of the total children's hospitals' inpatient charges. Newborns accounted for 50% of these hospital admissions. (NACHRI, 1987)
- * In 1980, the total cost for hospitalization of children with activity limitations ($1.17 billion) was 30% of the total hospital care costs ($3.86 billion) for all children. (Butler, 1985)

MILLIONS OF CHILDREN WITH NO HEALTH INSURANCE

- * In 1985, 11 million children age 18 or younger were uninsured. Among uninsured children, 64% lived in families headed by someone without health insurance; 29% lived in families headed by someone with employer-based health coverage, usually a parent. (Employee Benefits Research Institute [EBRI], 1987)
- * 3/4 of all uninsured children have family incomes below 200% of the federal poverty level, and between 66-75% live in working families. (Rosenbaum, 1987)

- In 1985, nearly 1/2 of the uninsured children age 18 or under lived in single-parent, usually female-headed, families. (EBRI, 1987)

- Children without any form of health insurance protection were most likely to be Hispanics and near poor children whose family incomes were between 100 and 200% of poverty. Children living in the South and West and in the rural areas were more likely than those in other regions and communities to lack coverage. (Butler, 1985)

- 10.3% of disabled children, and 19.5% of disabled children in poverty have no health insurance. (Butler, 1985)

- 40% of all disabled children below the federal poverty level are not covered by Medicaid. Private group and individual insurance covers about 60% of disabled children, compared to 75% in the general child population. (Butler, 1985)

- In FY 1985, Medicaid served 10.9 million children younger than 21 -- more than 400,000 fewer than were served in FY 1978. (Rosenbaum, 1987)

- Uninsured low-income children receive 40% less physician care and half as much hospital care as insured children. (Rosenbaum, 1987)

MILLIONS OF CHILDREN WITH INADEQUATE INSURANCE

- Of those children under 18 who are insured, 17% do not have major medical to cover special health care costs, and less than 10% have unlimited coverage. (NACHRI, 1987)

- Of all employers responding to a major health insurance survey conducted in 1986, 73% indicated that their plans excluded coverage of pre-existing conditions. Only about 75% of plans offered by medium and large-sized firms between 1980 and 1985 contained protections against huge out-of-pocket costs borne by enrollees in the event of catastrophic illness. (Rosenbaum, 1987)

- 14 state Medicaid programs limit the number of hospital days covered each year, and 15 states restrict the number of covered physician visits. (Rosenbaum, 1987; Fox, 1984)

3/23/87

SUMMARY OF HEARING ON "RACE RELATIONS AND ADOLESCENTS: COPING WITH NEW REALITIES" WASHINGTON, D.C., MARCH 27, 1987

On March 27, 1987, the Select Committee on Children, Youth, and Families held a hearing entitled, "Race Relations and Adolescents: Coping with New Realities." In light of recent incidents of racial violence among adolescents in communities across the country, the hearing was held to examine current trends in American race relations and their mental health implications for children and youth. The hearing was held in conjunction with the 64th Annual Meeting of the American Orthopsychiatric Association.

Hon. Floyd Flake, Member, U.S. House of Representatives, New York (6th District), told the Committee that while obvious signs of racism still occur, like the attack on three black youth by white teenagers that occurred in his district at Howard Beach, NY, subtle and more insidious racially related incidents are now more prevalent. He noted that the media plays an important role in creating and sustaining prejudiced attitudes towards blacks, especially among adolescents, in the choice of news events concerning blacks and in the use of negative stereo types. For example, television shows that depict poor black children adopted by white parents may foster a sense of superiority in white youth and a feeling that blacks need white parental guidance to learn social skills.

Part of the solution involves more minorities in positions of authority, such as teachers and policemen, to serve as role models for both black and white youth. Also, parents, the church, schools, government, and business must develop a partnership dedicated toward changing prejudiced attitudes.

Dr. Gary Orfield, Professor of Political Science and Education, and Director of the National Desegregation Research Project at the University of Chicago, documented demographic shifts in American schools and cities that are affecting race relations. He told the Committee that since 1972, there has been virtually no progress in integrating black students, and Hispanic students have become dramatically more racially isolated. In 1972, 63.5% of all black students and 56.6 percent of Hispanic students were enrolled in predominately minority schools; in 1980, 63.5% of black students and 70.6% of Hispanic students were enrolled in minority schools.

Dr. Orfield provided strong statistical evidence of a link between high levels of racial isolation, poverty and low academic achievement, stemming from conditions in many inner city minority schools where serious precollegiate preparation is simply not available. Orfield testified that children who grow up in ghettos or barrios are rarely offered the kind of training in the kind of setting that the majority of whites take as a basic right and expectation.

Bruce Kelley, Program Director of California Tomorrow, told the Committee about rapid demographic shifts involving immigrant groups in California. Currently in California, 1/4 of the 4.2 million public school children are Hispanic, 1/8 are Asian, another 1/8 are black, and over 500,000 in the state do not speak English. According to projections, within a generation, whites will comprise barely a third of school enrollment.

Based on interviews with nearly 300 immigrant children in California schools, Kelley reported that volatile race relations are a real and pervasive problem for immigrant youth, often leading to fear, abuse and occasional violence. For example, every Asian immigrant interviewed indicated that she/he had been provoked, robbed, made fun of, or otherwise harrassed. According to Kelly, race-related problems also isolate immigrants from other students, obstruct the process of learning English, and damage student achievement. In both verbal and math tests, 12th grade Asian immigrants scored below the state average.

Commissioner Frederick Hurst of the Massachusetts Commission Against Discrimination reported the results of his investigation of an attack by hundreds of white students on 20 to 30 black students following the loss by the Boston Red Sox to the New York Mets at the final game of the 1986 World Series.

Hurst indicated that on one level, the attack reflected white Red Sox fans' frustration at the loss to the Mets, who were considered by them to be a "black team," and the displacement of those frustrations onto black students. But, in his view, the attack also reflected the fact that many of the white students involved were from ethnic Boston neighborhoods in which antipathy to affirmative action, busing and integrated housing is substantial. Hurst reported that students' comments during the investigation suggested that negative stereotypes of minority students -- especially black students -- had been taught and reinforced in white homes and were carried to the UMASS campus by students. According to the investigation, these young white students possessed little knowledge of civil rights struggles of the recent past and tended to be casual about expressing their negative racial sentiments in the form of racial graffiti and jokes, racial epithets and physical racial attacks.

Dr. James Comer, Maurice Falk Professor of Child Psychiatry at Yale University, testified that documented facts concerning past conditions for minorities are not known to most leaders, the general public, and most particularly, our young. He indicated that, as a result, during this period of rapid adjustment to massive changes occurring in our economy, "racial scapegoating" is recurring as a product of uncertainty and anxiety -- despite recent and continued signs of increased racial tolerance within our society. Comer argued that it is a particular problem for today's youth in that they did not live through the period of legal discrimination and abuse or the era of intensified struggle for civil rights, and resultant improved race relations. As a result, they have no way of understanding the demand from blacks for equal opportunities within the mainstream of the society, or the conditions that exist because of the denial of such opportunities in the past.

Dr. Margaret Beale Spencer, Associate Professor of Developmental and Educational Psychology at Emory University, Atlanta, informed the Committee of the significant effects of children's awareness of racial differences, and of racism, based on her interviews of black Atlanta children ages 3 to 9 before and after the so-called "Atlanta child murders," the random killing of young black males in 1980-1981.

Spencer indicated that black children as young as 3 years old are aware of society's negative evaluation of the color black;

when they reach age 5 or 6, this negative association becomes a significant issue in the development of self-esteem. Also, young black children exhibit a heightened sense of vulnerability and fear because of race. Sixty percent of the children interviewed said that "the law" would have solved the murders sooner if the children killed had been white, and 96% believed that the systematic killing of black youth could happen again, even after the primary suspect had been apprehended and convicted of the crime.

Spencer testified that these kinds of race-related early psychological trauma contribute to the disproportionately high level of teen pregnancy, school failure, interracial violence and incarceration experienced by black youth, especially males.

Dr. Lillian Comas-Diaz, Co-Director of the Transcultural Mental Health Institute in Washington, DC, described the adjustment problems of Salvadoran immigrant youth who have settled in Washington, DC, which for many is their first encounter with racial diversity. Comas-Diaz told the Committee that racial tensions between Salvadoran and black adolescents have been reported in this city, and in some instances have escalated the formation of violent racial/ethnic gangs. She indicated that financial constraints and the competition for scarce resources between blacks and Salvadorans in low-income inner city communities broaden the gap between these two ethnic groups. Also, many Salvadoran parents tend to over-protect their offspring, transplanting the behaviors used in El Salvador to the United States. According to Comas-Diaz, within this context, the "other" is the enemy, and parents emphasize that survival, regardless of the means, is a must.

Comas-Diaz also noted that while some male Salvadoran youth are forming gangs for both a sense of belonging and "protective purposes," Salvadoran girls tend to turn their fears and frustration inward, resulting for some in depression, alcohol abuse and suicidal tendencies.

Renato L. De Maria, Principal of New Dorp High School on Staten Island, NY, told the Committee about a human relations program in that school which is now used as a model throughout the state. Developed in the aftermath of a serious racial incident at the school in 1980, the program includes a Community Advisory Council representing the interests of all racial and ethnic groups in the community; a Youth Outreach Program consisting of human relations workshops for all incoming freshmen, and a conflict mediation team composed of trained counselors, teachers and students.

De Maria indicated that, while there have been racial clashes between students, since the introduction of the program, no instructional time was lost and, in each instance, a sense of calm was maintained.

SUMMARY ON FULL COMMITTEE HEARING ON "CONTINUING CRISIS IN FOSTER CARE: ISSUES AND PROBLEMS" WASHINGTON, D.C., APRIL 22, 1987

On April 22, 1987, the Select Committee on Children, Youth, and Families held a hearing entitled, "Continuing Crisis in Foster Care: Issues and Problems." This hearing examined federal and state provision of preventive services to children at risk of foster care placement, the status of children in foster care, and barriers to independent living and adoption of foster children.

Dodie Livingston, Commissioner, Administration for Children, Youth and Families, Office of Human Development Services, U.S. Department of Health and Human Services (DHHS), represented the Department and was accompanied by Joseph Mottola, Deputy Commissioner, Administration for Children, Youth, and Families, and Jane Burnley, Associate Director, Children's Bureau. Livingston began the hearing by testifying to the progress states have made since the enactment of P.L. 96-272, The Child Welfare and Adoption Assistance Act of 1980, and the Department's role in administration and oversight. She cited several indicators of progress: reduction of the number of children in foster care (502,000 in 1977; 275,000 at the end of 1985); shorter time spent in foster care (27 months in 1980; 18 months in 1985); more children reunited with their families (50% in 1982; 67% in 1985); fewer children in institutions (70,280 in 1977; 27,500 in 1985); more special needs children adopted; and more children in permanent placements. Upon questioning, Burnley noted wide variation among the states with regard to these indicators. She added that, since 1984, there has been a small general trend toward increased numbers of children placed in foster care.

Livingston then outlined for the Committee two of the Department's oversight activities. Section 427 Compliance Reviews are conducted to verify a state's eligibility for additional Title IV-B (Child Welfare Services) funds by reviewing state administrative procedures and a sample of case records. Livingston noted that currently all but six states and jurisdictions meet the requirements. Title IV-E (Foster Care Maintenance Program) financial reviews are conducted to review the state's foster care maintenance payment program, the adoption assistance program, and administrative costs charged to Title IV-E.

Livingston also described two legislative proposals requested by the Department. One would limit federal matching payments for administrative costs incurred in foster care and adoption assistance to 50% of maintenance costs. The Department submitted that such legislation is needed to halt the growth of administrative cost claims, which were 500% higher in FY 1985 than in FY 1981. The other proposal requests repeal of the Independent Living Initiative, enacted in 1985 to help older youth in foster care make the transition to independent living. While the repeal request stands, Livingston noted that the Department is proceeding to solicit applications to implement the program in FY 1987. Livingston concluded her testimony by emphasizing the goal of permanency for children, and describing the variety of the Department's discretionary activities and initiatives on child welfare issues.

William J. Grinker, Commissioner, New York City Human Resources Administration, New York, testified next regarding child welfare services in New York City. He noted that federal support to New York City for child welfare programs were dramatically reduced at the same time needs changed and problems grew. He added that, while cutbacks in Title XX (Social Services Block Grant) funding and the slower than expected growth in Child Welfare Services funding (Title IV-B) caused difficulties in fully implementing the preventive and reunification system required by P.L. 96-272, the State and the City have met the provisions of the federal legislation. Grinker stated that between 1985 and 1986, New York City experienced a 15% increase in reports of child abuse and neglect due to both greater public awareness and increases in poverty and drug use. Between 1985 and 1986, the number of families receiving services increased 14%. The expanded use of preventive services helped reduce the foster care caseload from 25,000 in 1978 to 16,500 in 1985, but today, the number stands at 17,500 and is climbing.

The increasing number of births of medically fragile babies presents another growing problem. Currently, about 210 infants, who have been medically cleared for discharge, are waiting in hospitals for foster care placement. Grinker cited the City's "Boarder Baby Plan" which includes "returning to home babies who can go home or placing babies in foster care within seven days of medical clearance by the end of October," and the development of adequate facilities for babies with severe medical/developmental problems. Grinker also noted that it has become harder to locate adoptive homes, especially for older children. He reported that, at the end of February, the City had placed only slightly more than 50% of the June 30 year-end goal of 1,200 placements.

In conclusion, Grinker stated that adequate financial support for services that strengthen and preserve families is a responsibility shared by all levels of government, and that more generous federal support should be provided for Title XX day care services; programs for teens in foster care; expansion of Title IV-E to create a special foster care program for teen-age girls with children of their own; independent living programs for older children; research; and the recruitment and training of foster parents and foster care staff.

Michael Reagen, Ph.D., Director, Missouri Department of Social Services, Jefferson City, MI, and Chairman of the Management Committee, American Public Welfare Association's National Council of State Human Services Administrators, cited several areas of progress following the enactment of P.L. 96-272, including: making permanency planning for children more widespread; placing fewer children in foster care; and decreasing the time children spend in foster care. Reagen reported that currently problems in the foster care system are worsening because of more children entering the system who are older, have multiple problems, and come from more disorganized, often abusing families. In addition, the pool of foster homes, especially in urban settings is shrinking, and reimbursement rates for foster parents are inadequate.

Reagen testified further that the states have been left to implement the new foster care and adoption program without "full federal guidance from the Department of Health and Human Services," and without adequate program funding. He reported that DHHS has not reimbursed Missouri for $11.5 million in outstanding undisputed foster care payments. Nationally, the American Public Welfare Association reports that back claims due 30 states total more than $400 million. According to Reagen, DHHS lacks sufficient funds to make the payments, and a supplemental budget request will cover only a portion of the claims.

Reagen added that states are hampered further in their implementation of P.L. 96-272 because of the absence of promulgated federal standards or regulations, or finalized review guides, leaving states at a loss as to how best to proceed. Reagen also submitted that administrative costs have risen rapidly because states have learned better how to document legitimate claims for administrative activities, such as case planning and supervision, recruitment, and court appearances -- all allowable activities to protect children and promote permanency under the law.

Gordon Johnson, Director, Illinois Department of Children and Family Services, Springfield, IL, also testified that positive changes have occurred in Illinois because of P.L. 96-272, including a decrease in both the number of children in substitute care and in the time spent in substitute care. The number of children awaiting adoption has decreased, and completed adoptions have increased by 50%. Johnson also noted problems with implementation, particularly in working with the judicial system. Johnson described difficulties keeping judicial personnel adequately informed of the requirements of P.L. 96-272, and in the process to determine whether "reasonable efforts" have been made.

Johnson stated that increased numbers of abused and neglected children have caused Illinois to increase their resources for preventive and in-home services. The role and purpose of foster home care has shifted to a temporary service with emphasis not only on protections, but also on securing real permanency for the child. To achieve these goals, Illinois initiated a major restructuring of the foster care system to create a more professional role for foster parents, and to team foster parents and direct service staff. Johnson concluded by advocating that the federal government support new initiatives for foster care services, as well as sustain current levels of funding to improve foster care services, including full funding of Title IV-E training for staff and foster parents.

Linda Greenan, Senior Policy Analyst, Child Welfare League of America, Inc., Washington, DC, focused her testimony on the Administration's FY 1987 and FY 1988 budget proposals for child welfare programs. She described the newly enacted Independent Living Initiative (ILI) designed to help adolescents make the transition from foster care to independence. Greenan noted that Congress fully funded the ILI at $45 million for FY 1987, but to meet a "shortfall" in the Title IV-E program, the Administration proposed to reprogram the entire ILI appropriation. Both the House and Senate Appropriations Subcommittees on Labor-HHS-Education indicated to HHS their concern and/or disapproval f the reprogramming requests. For FY 1988, the Administration requested repeal of the program. The Administration now says that it will fund and implement the ILI for FY 1987, but according to Greenan, they have effectively delayed the start of the program by about one year.

Greenan also expressed concern about inadequate funding for Title IV-B services. Despite the fact that Congress has increased funding each of the past three years, the FY 1987 level of $222.5 million falls far short of the authorized $266 million. Greenan concluded by urging full funding of Title IV-B Child Welfare Services to insure the provision of preventive and/or reunification services.

Brian F. Cahill, Chairman, Public Policy Committee, California Association of Services for Children; and Executive Director, Hathaway Children's Services, Los Angeles, CA, concluded the second panel stating that the issues concerning children in substitute care should not be considered outside the context of a comprehensive system of protections and services for vulnerable children. He said that many of the problems of 24-hour care of children relate directly to the lack of early intervention and treatment resources. Cahill noted that California has serious emergency shelter care problems because there is no place for many children to go after they have entered the system; as a result, short-term shelter becomes long-term maintenance. Cahill called for a continuum of care including needs assessment, early intervention, non-residential treatment services, foster family and group care, residential treatment services and after care services.

Cahill agreed that P.L. 96-272 has had a positive impact, but added that until early intervention services and alternative services to foster care are available, there will continue to be problems. In California, there is no Title IV-B funding for in-home services or day treatment, and Cahill recommended funding these services. He also recommended making Medicaid funds available to non-hospital residential treatment centers to provide mental health treatment as an alternative to psychiatric hospitalization for multi-problem children. Cahill also described some promising developments in California, including the Ventura County Children's Demonstration Project, an interagency effort to plan and provide case management for multiple problem children, and the Los Angeles Roundtable for Children.

Toni Oliver, Consultant and Adoption Specialist, National Center for Neighborhood Enterprise, Washington, DC, began the third panel by applauding the intent of P.L. 96-272, but said that "its implementation has not mirrored its intent, particularly for black children." Oliver stated that, while the total foster care population declined between 1977 and 1982, the percentage of minorities increased from 36% to nearly 50%, 80% of whom are black children. She added that black children comprise 33% of the children who have had parental rights terminated in order to be legally free for adoption yet they comprise 69% of the nonhandicapped children free for adoption but not in adoptive placements. Oliver stated that agencies across the country have been unable to provide adequate prevention and family preservation services due to a lack of understanding about how to deliver these services, lack of staff and resources, lack of good and consistent information, inadequate coordination of systems, and attitudinal barriers to considering and accepting prospective adoptive families who do not fit the "American Dream."

Oliver recommended that a national family policy be established that would mandate all families at risk of having children placed into foster care receive intensive preventive services, and that agency activities be monitored at the federal level "through a mandated and uniform reporting system that is systematically reviewed to determine compliance, significant trends in practice and the impact of services on children and their families."

Pamela Elsner, Executive Director, Illinois Action For Children (IAFC), La Grange, IL, described IAFC's 3-year courtwatch project on the delays for children in foster care, and related issues identified through a project of the Illinois Task Force on Permanency Planning sponsored by the National Council of Juvenile and Family Court Judges. In Illinois, 1 out of 5 children is poor; child abuse hotline calls have increased 8.3% over the past year (35% resulted in founded reports); and 82 Illinois children died from abuse or neglect in the year ending June 30, 1986, a 49% increase from the previous year. The juvenile courts and the Department of Children and Family Services have joint responsibility to protect children, but according to Elsner, caseworkers are overburdened; foster parents, who increasingly deal with more difficult youngsters, lack adequate training and support; and the judicial system is overloaded.

Elsner attested to foster care cases delayed from 6 months to 3 years in the welfare/juvenile court system, despite a legal requirement of 120 days for an adjudication hearing. This results in delayed disposition, delayed reunification, delayed permanent placement. Elsner presented recommendations to improve services, including establishing timeframes for hearings; creating an entity outside the agency or juvenile court to review progress on cases and identify problems; and developing intensive home-based services statewide that support the child and family.

Ernesto Loperena, Executive Director, New York Council on Adoptable Children; and President, North American Council on Adoptable Children, New York, NY, as the final witness, testified that of the 250,000 children now in foster care, 36,000 are freed for adoption, with blacks, Hispanics and Native Americans comprising 47% of this population. In New York City, 17,000 children are in foster care; of whom 3800 -- 90% of whom are black and Hispanic -- have the goal of adoption. The barriers to adoption of these children include, on average, 6-year waits by children in foster care; long delays for families who enter the adopting process; difficulties posed by the so-called matching process where a family selects a specific photolisting but fails to qualify as the "ideal" family situation. According to Loperena, perhaps the most pervasive systemic problem is the built in financial incentive to maintain children in foster care as opposed to either reunification or adoption. Since both public and private agencies are reimbursed on a per diem/per child basis, the way to maintain or enhance the budget is by keeping children in foster care.

Loperena provided examples of graduates of the foster care system who were unable to live independently because they had not been provided with basic life skills, and he strongly recommended an independent living program for all children entering foster care in order to avoid this tragedy.

CHILDREN IN FOSTER CARE

FACT SHEET

NUMBERS OF CHILDREN IN FOSTER CARE INCREASING AFTER SIGNIFICANT DECLINE

* The estimated average monthly number of children in AFDC foster care in FY'87, 109,000, was the highest of any year since 1980. (Congressional Research Service, April, 1987)

* In 1977, an estimated 500,000 children were in foster care, dropping to 269,000 by 1983. In 1984, the number of children in foster care rose by 2.6% to 276,000. (Department of Health and Human Services [DHHS], August, 1986)

* Between 1980 and 1984, state foster care trends varied widely. 22 states showed an increase [e.g., California (40%); Illinois (26%)], while in 29 states the number of children in foster care decreased [New York (-36%); Florida (-35%); District of Columbia (-21%)]. (DHHS, August, 1986).

* In New York City, 23,657 children were in care in 1977, declining to 16,230 in 1983. Currently, 17,500 children are in care, with further increases expected. (NYC Human Resources Administration, Office of Special Services for Children, 1987)

* In San Francisco, approximately 2400 children were in foster care in 1986, compared to 1400 in 1985. Referrals continue to rise, as does the severity of the offenses requiring intervention, and the number of petitions filed. (Grandin, Interagency Committee on Abuse and Neglect, Mayor's Advisory Council on Children, Youth, and Families, San Francisco, 1986)

INCREASING NUMBER OF INFANTS, CHILDREN AT RISK OF OUT-OF-HOME PLACEMENT

* In a survey of the 50 states and the District of Columbia, the number of children reported to have been abused or neglected rose 55% between 1981-85. Between 1984 and 1985 alone, child abuse reports increased nearly 9%. In addition, many states reported increasingly more serious and complex cases. (Select Committee on Children, Youth, and Families, "Abused Children: Victims of Official Neglect," [hereafter cited as Select Committee], 1987)

* In Los Angeles County, dependency petition filings due to excessive drug use by a parent increased 1100%, from 241 to 2857 cases between 1981 and 1986. Dependency petition filings due to drug ingestion of minors or infants in drug withdrawal increased 933% over the same five year period. In 1986, substance abuse related referrals represented 21% of the total 20,096 filings. (McIntosh, Select Committee hearing, "AIDS and Young Children: Emerging Issues," 1987)

* In 1985, 1230 live births with drug involvement were reported to the New York City Department of Health, a rate

of 10.4 per 1,000 live births -- up from 7.9 per 1,000 in 1983. (NYC Department of Health, 1986)

- In the New York City public hospitals in November 1986, approximately 100 children age 0 - 2 were awaiting foster care placement; another 50 children were awaiting court or social services determination on appropriate disposition; and 30 more children over age 2 were awaiting placement or disposition. Between 50 and 60% percent of infants awaiting placement for at least ten days had mothers who were drug abusers. (NYC Health and Hospitals Corporation, 1986)
- As many as 50% of homeless youth seeking housing in New York City shelters had a history of foster care placement. (Shaffer and Caton, "Runaway and Homeless Youth in New York," 1984)
- California shelters are experiencing increased admissions of infants and younger children. For example, one county reports that 40% of their shelter children are under 6 years of age; another county has over 100 infants in shelter care with the majority diagnosed as failure to thrive or having drug-dependent mothers. (Children's Research Institute of California [CRIC], 1985)

CHILD FATALITIES RISE

- The estimated number of child deaths due to maltreatment increased by 29% from 1985 to 1986, in contrast to a 2% decline in the number of child deaths between 1984 and 1985. (National Committee for the Prevention of Child Abuse, 1987)
- Comparison of 7 California counties' mortality statistics on foster care and emergency shelter children showed that San Francisco ranked 5th in population, 3rd in total number of children in foster care, 5th in emergency shelter care admissions, but 1st in number and rate of deaths per 1,000 children in foster care during the study period. ("Deaths of Children in Foster Care and Emergency Shelter Care, A Preliminary Report," Mayor's Committee on Foster Care, San Francisco, California, August, 1986)
- New York City's review of child fatalities occurring in families previously known to the division of Special Services for Children revealed a marked increase in the number of fatalities during 1986 which were clearly due to established parental or caretaker abuse. In 1985 there were 9 such cases; in 1986 there were at least 14. (NYC Human Resources Administration, 1987)

STATES UNABLE TO KEEP PACE WITH NEEDS TO PREVENT PLACEMENT AND TO PROVIDE PERMANENT HOMES FOR CHILDREN

- In 27 of 31 states reporting complete information in response to a survey regarding child protection and child welfare services, resources to serve abused and neglected children declined in real terms, or failed to keep pace with rapidly increasing reports of child abuse. (Select Committee, 1987)

- * Illinois reports a 43% reduction in licensed foster homes between 1983 and 1986, from 7,007 down to 3,954. (Illinois Human Services Plan Phase II, Illinois Dept. of Children and Family Services, 1986)

- * In California, the average length of stay for a child in shelter care is nearly 40 days. Thus children are remaining for an extended period of time in a system designed to be temporary. (CRIC, 1985)

- * In San Francisco, workers providing voluntary family support services vital to early intervention and prevention of child abuse are being transferred to out-of-home placement units to assist in handling of increased caseloads. From May 1985 to May 1986, there was a 94% increase in the number of cases carried by workers in the Court Dependency Unit, reflecting a shift away from a prevention focus in the handling of the cases. (Grandin, 1986)

- * Also in San Francisco, court delays and inadequate long-term placement resources are resulting in increased lengths of stay in temporary shelter placements; currently the average young person stays in emergency shelter over two months before moving on. The time needed to resolve petitions increased 77% over last year. (Grandin, 1986)

FAMILY PRESERVATION AND SUPPORT PROGRAMS REDUCE OUT-OF-HOME PLACEMENTS

- * States identified child abuse prevention and treatment programs which, according to evaluations, have successfully prevented child abuse, reduced recidivism, improved family functioning, avoided costly treatment and prevented placement of children in foster care. (Select Committee, 1987)

For example:

District of Columbia: Since its inception in October 1985, the "Preventive Family Counseling Program" has provided services to 40 families. The program prevented placement of 141 children at imminent risk of removal; only 7 children were recommended for foster care placement.

Florida: The "Intensive Crisis Counseling Programs" (ICCP) served 107 families with 302 children. Of the 196 target children seen, only 5 had been removed by the state at the time ICCP services were terminated (a 97.4% success rate). 92 of these families were still intact. Follow-up at 1, 3, and 6 months showed 85.7, 65.5 and 80.0% success rates. A conservative estimate indicates that a single ICCP with 3.5 fulltime equivalent therapists may net the state $619,290 in avoided placement costs.

Nebraska: The "Intensive Services Project" served 34 high-risk families during its first year. In 86% of the cases (24 of the first 28 cases), placement was averted. A revised and extended version of this project, "Home-Based Family-Centered Services," decreased the number of children placed out of the home by 10% in its first 2 years. In its first year, therapists reunified or prevented placement in 90.4% of the 248 families they saw.

Rhode Island: "Comprehensive Emergency Services" (CES), using parent aides, respite care and early diversionary services, prevented foster care placements in 92% of its cases and prevented intervention by the Department of Children and Their Families in 83% of its cases. Cost-effectiveness analyses indicate that CES may save the state over $3 million in averted foster care placements.

Virginia: Of the 715 children at risk of placement who were treated by the "Preplacement Preventive Services Program," which provides family structured therapy and/or home-based services, only 7% were removed, and these children remained in placement for a shorter duration than other foster care children. Sixty-nine percent of the 391 families improved in overall family functioning. The average cost to prevent placement is $1,214, while the average annual cost for foster care is $11,173 and for a residential facility is $22,025.

4/22/87

SUMMARY ON FULL COMMITTEE FIELD HEARING ON "CHANGING ECONOMICS IN THE SOUTH: PREPARING OUR YOUTH" NASHVILLE, TENNESSEE, APRIL 24, 1987

The Select Committee on Children, Youth, and Families held a field hearing in Nashville, Tennessee, April 24, 1987, that examined the economic, educational, and occupational futures of children and youth in the Southeast, in light of recent economic and demographic changes in the region.

Timothy J. Bartik, Assistant Professor of Economics, Vanderbilt University, Nashville, TN, discussed changing economic conditions in Tennessee and the East South Central states. He reported that, since 1973, Tennessee's growth has been relatively slow, reflecting the general economic decline in the region after years of some growth. In 1984, the region had the highest unemployment rate of the nine U.S. Census regions; it was the third lowest in 1976. Bartik cited two principal causes of the State's slow economic growth: the end of post-World War II low-wage manufacturing, and the State's relatively weak position in business services, which comprise one of the fastest growing sectors in the economy. He stated that this weakness is partly due to less urbanization in Tennessee than in the U.S. In 1980, the State's population was almost 40% rural compared to 26% in the Nation.

Bartik pointed out that, at the same time as the economic slowdown reduces labor demand for everyone, including youth, jobs in Tennessee are increasingly requiring higher skill levels. The manufacturing base is shifting towards industries requiring higher skills, and even traditional lower-wage industries have developed more advanced technology and skill requirements. Bartik cited a shortage of skilled labor to fill jobs, underscoring the need to ensure that youth are adequately trained. To address these labor market problems in the State, Bartik recommended: reducing the federal deficit in order to reduce the trade deficit and benefit Tennessee, since much of its manufacturing depends on imports; building additional interstate highways to provide job corridors between rural and metropolitan areas; and developing smaller urban centers in rural areas. Bartik also said that schools and training programs must do better at helping youth master literacy and math skills, as well as the skills needed for craft and technical jobs; and that there is growing need to link rural youth with possible jobs in urban areas.

Roy H. Forbes, Ph.D, Executive Secretary, Southern Rural Education Association; and Rural Education Consultant, Southeastern Educational Improvement Laboratory, Research Triangle Park, NC, followed with an overview of education in the Southeast. He testified that the South, especially the rural South, is playing an educational catch-up game. National student performance data historically and currently has shown the Southeast to lag behind the other regions of the country. Forbes attributed the disparity between the South and the rest of the Nation in part to the legacy of using education to keep "blacks in their place,...whites in the textile mills," and to maintain a "cheap labor supply" for industry.

Forbes added that an environment was created that placed a limited value on education and restricted resources that went into public elementary and secondary education. Among the

Southeastern states, only Florida spends at or above the 1985-1986 national average per pupil expenditure of $3,675. The others range from North Carolina, which spends 92% to Mississippi, at 63%.

Forbes said that, today, a different set of economic considerations have resulted in education being viewed as critical to the economic well being of the region. He noted that reform actions have swept the South, mandating more accountability, higher standards for students and staff, and improved learning opportunities and support services. He added that, with the implementation of reforms, some new problems have emerged especially in rural education where conditions and challenges have typically been more difficult. He noted as an example, that North Carolina's funding formula associated with the basic education program does not work for high schools of less than 350 students. In conclusion, Forbes said that reforms will help to close the basic skills gap, and that the future of the region depends upon the ability of the population to use those basic skills, to participate successfully in job training, and to be able to think and solve problems.

Karen Weeks, Research Associate, Tennessee State Board of Education, Nashville, TN, testified on the link between economic health and good schools; the reform efforts currently underway in Tennessee; the results accomplished to date; and sustaining the momentum for improvement. The first priority of the new State Board of Education, created by recently enacted education reforms, is to improve student achievement. It has initiated a "Basic Skills First" program in grades 1-8 to ensure the mastery of specified reading and mathematics objectives at each grade level. At the high school level, curricular changes are being designed to ensure that high school students have mastered the academic subjects and competencies required to succeed in college or to enter the job market upon high school graduation. In addition, a statewide task force on vocational education concluded that vocational studies must emphasize the mastery of basic skills such as reading, and the ability to reason and solve problems.

State assessments so far show improved performance, particularly in the lower grades, according to Weeks, and the task is to sustain that level of achievement as students move through school. To ensure continued progress, Weeks argued that the State must not be overly prescriptive, but instead should enhance the capacity of local leaders and teachers.

John Gaventa, D.Phil., Director of Research, Highlander Research Center, and Assistant Professor of Sociology, University of Tennessee at Knoxville, next described Appalachia as being in a state of economic crisis "as deep as the one which called the War on Poverty into being 20 years ago." While hope for the region was generated during the 1970's, he said that during the first half of the 80's, almost 2/3 of the counties in the region have declined economically relative to the rest of the nation. At the end of 1985, 4/5 of the region's counties had an official unemployment rate higher than the national rate of 6.7%.

Gaventa pointed out that the Appalachian region has experienced the effects of changes in the economy much more severely than many places in the Nation. In the past, parts of the Appalachian South benefitted from industrial migration from the

North. Today, plants are closing and/or moving overseas. According to the Appalachian Regional Commission, in the first 4 years of the 1980's, the region lost 2-1/2 jobs for every one created in the 1970's. Gaventa added that the promise of a new service economy has not materialized; growth of service jobs in the South, especially in rural areas, has been lower than elsewhere in the Nation.

As a result of these changes, the gap between the region and the rest of the Nation is widening and there is a "rapid deepening of the Two Souths -- the urban, growing, somewhat prosperous cities...and the declining, rural South, where unemployment remains 37% greater than in urban areas." Gaventa discussed the impact of the changes on youth in several areas: hunger, dropout rates, illiteracy, job training. He concluded that while education and training strategies are important to solving these problems, more is required. He said that the root causes of the crisis must be examined and economic solutions, including a national commitment to employment, are needed.

Lamont Carter, President and Chief Executive Officer, Oak Ridge Chamber of Commerce, Oak Ridge, TN, concluded the first panel with testimony on meeting future job skill needs in Tennessee. The former Governor's Job Skills Task Force, on which Carter served, reported that growth in the next decade will be greatest in the service sector (e.g., medical, financial, communication and transportation services); and that entry level employees, as well as for highly skilled workers, will be in high demand. Carter also noted that employers emphasized the importance of a good basic education, and listed a lack of basic interpersonal skills as a chief reason for employees failing to move up.

Among its recommendations, the Task Force called for (1) development of an education and training policy which formally demonstrates the State's commitment to developing a higher quality labor force; (2) definition of statewide strategies for stimulating business expansion and attracting new industries; (3) reorganization of vocational and technical education to eliminate duplicated services, make systems more responsive to changing occupational requirements, and spur closer interaction between business and education; (4) formation of a statewide business and industry advisory board; (5) development of a statewide education and training program, which, among other things, has an ongoing mechanism to identify changes in projected labor needs, specific curricula to teach the basics, incentives to attract high-quality teachers, and strategies to facilitate more formal links between employers and schools; (6) development of a special task force to coordinate the design and delivery of computerrelated instruction; and (7) development of a cooperative statewide industry/education pool of communication equipment and services.

M. Hayes Mizell, Coordinator, State Employment Initiatives for Youth Demonstration Projects, Columbia, SC, testified regarding the futures of undereducated and underserved youth in the South. He reported that, in 1965, 60% of youth (59% of them black) who started 1st grade in 1953 did not graduate 12 years later. Thus far during the 1980's, State Department of Education officials have identified 79,304 students as dropouts. Mizell noted that the trends help explain why, in 1985, 912,640 adults in South Carolina did not have a high school diploma.

He added that, while there are programs in the state to address the needs of this underserved population, it is more expensive, and less effective to reeducate and retrain than it is to educate and train in the first place. He called school-age youth who drop out of school, or who graduate from high school without the basic skills that can enable them to obtain good jobs, the displaced workers of the future.

As a result of South Carolina's education reform initiative in 1984, progress has been made. The State is spending $55 million in state funds to provide compensatory and remedial education to approximately 245,000 students who do not meet basic skills standards; and $8.6 million to prepare about 4,000 4-year-olds at risk of serious learning problems when they enter school. All preschoolers in the state are in a kindergarten program with the highest rate of daily attendance in the Nation; more students are moving out of the bottom quartile of achievement on national basic skills test; and last year, nearly 80% of the over 12,000 vocational students available for jobs were employed in related areas, were continuing their education or had entered the military.

According to Mizell, the State is hopeful that a combination of early intervention, higher academic standards, strict accountability, and the improved preparation and compensation of teachers will result in raising students' achievement levels. However, there is concern that, if present trends continue, and insufficient attention is paid, some 15,300 of the 51,000 students in the 9th grade will withdraw from school before 12th grade. Mizell said that neither South Carolina, nor any other southern state can afford to lose 15,000 students, or more, from each graduating class. He said states must be committed to education reform as an ongoing process; marshall resources to keep young people in school; and develop ways to help them make the transition to productive employment.

Max Snowden, Education Liaison, Arkansas Advocates for Children and Families, Little Rock, AR, reported that, in Arkansas, each year thousands of students drop out of school or are excluded from attending for varying periods of time. Currently, more than 700,000 Arkansans have less than a high school education, and at current rates over 10,000 will be added to that number each year. Dropouts are of great concern not only because of expanding numbers, but because the consequences of leaving school early are becoming more severe. Economically, Arkansas faces high unemployment and loss of traditional industries. It also faces an absolute decline of entry-level workers, and an inadequate pool of skilled workers to fill new positions.

Snowden described the new Governor's Task Force on At-risk Youth that brings together state agencies, business leaders, youth and others to address problems of at-risk youth in a coordinated way. Components of the effort include: (1) additional training of elementary and secondary school counselors and administrators in identifying and working with at-risk youth in school; (2) development of education-for-employment committees to provide youth with experiences with the real work world; (3) activities to connect students to services outside the school system; and (4) evaluation of existing policies and procedures to determine their impact on students leaving school. Snowden also described several other projects to improve attention and resources devoted to at-risk youth, including Winthrop Rockefeller Foundation support of school-connected programs;

efforts by the Little Rock School District to institutionalize special school-level programs; an endowment fund provided by the Arkansas Community Foundation to support projects for at-risk youth; and a model early intervention program to enhance school readiness of educationally disadvantaged children and increase parent participation.

Della Hughes, Executive Director, Oasis Center, Inc., Nashville, TN, described Oasis, a local, comprehensive youth serving organization and its Youth Employment program. The program began in 1985 as a job club and evolved into a multi-component training and job placement program. Designed to provide youth ages 16-19 with the knowledge and skills needed to secure and maintain employment, Oasis consists of a two-week training course, employment search and placement, follow-up, aftercare, and related youth employment activities.

Participants are recruited from housing projects, the juvenile court, churches, social service agencies, by word of mouth and other publicity. Many are low income, homeless or in foster care and/or independent living situations, or teen parents. Many also have dropped out of school and never have held a job. Hughes described several barriers to adequate preparation and employment of high risk youth, including the lack of affordable child care resources for teen parents; an inadequate local transportation system which makes it difficult for young people to get to and from a job; and multiple personal problems faced by troubled youth. The program reported 82% of participants placed in jobs in 1985; 84% placed in jobs or continuing education in 1986; and 85% placed in jobs through February, 1987.

Chris Rodgers Arthur, Ph.D., Coordinator, "I Have A Future" Adolescent Pregnancy Prevention Program, Department of OB/GYN, Meharry Medical College, Nashville, TN, testified regarding poor and minority youth who face significant odds against success, and how early child-bearing limits those options further. She noted that 85% of teenage heads of household are poor and unable to earn a way out of that cycle for themselves or their children. While Arthur advocated for improved education and remediation strategies for youth who lag behind in attainment of basic skills, as well as more substantial employment opportunities, she emphasized that real solutions involve long-term, comprehensive strategies that take the "whole child and his whole life into consideration." She added that this view does not minimize the need for intervention, but rather underscores the importance of prevention. She also described for the Committee a new effort in Nashville that has targeted a neighborhood to deliver services to young people and their families in a comprehensive fashion.

Paulette C. Fewell, Executive Director, Tennessee Council on Economic Education, Nashville TN, concluded the hearing with testimony on educating youth about the American enterprise system. According to Fewell, studies concerning people's knowledge and attitudes about business and economic concepts conclude that the majority of those polled lack accurate information, and most people get whatever information they have from television. She described the work of the Tennessee Council on Economic Education with teachers and students at all grade levels to promote greater knowledge and appreciation of free enterprise. She reported that, over the last 10 years, over 2000 Tennessee teachers participated in Council workshops at 9 universities across Tennessee. She stated that "by training teachers and creating success stories in economic education, the Tennessee Council on Economic Education is improving economic understanding and helping our youth build for a better tomorrow."

CHANGING ECONOMICS IN THE SOUTH: PREPARING OUR YOUTH

FACT SHEET

POPULATION GROWTH IN THE SOUTH OUTPACES NATIONAL TRENDS

- Between 1980 and 1985, the population in the South increased 7.5% compared to 5.4% nationally. By the year 2000, southern population rates are projected to climb 31%. (Southern Growth Policies Board [SGPB], A Profile of the South, 1986-1987, 1986)

- Metropolitan counties in the South are growing twice as fast as rural areas. Most of this growth is occurring as the result of migration rather than live births. (SGPB, After the Factories, Changing Employment Patterns in the Rural South, December, 1985)

- 38% of persons living in the South reside in rural areas compared to 26% in the U.S. as a whole.

- 20% of the population in the South is black compared to 8.9% in the rest of the nation. (SGPB, Profile, 1986)

POVERTY AMONG CHILDREN HIGHEST IN SOUTH

- 4 out of every 10 poor children in the U.S. live in the South. In 1985, 22.2% of children under 18 in the South were poor, a higher proportion than in any other U.S. region. For black children, the poverty rate was 42.6%. (U.S. Bureau of the Census, Consumer Population Survey, 1986, unpublished data)

- In 1983, nearly 20% of the total population in the South lived below the federal poverty level compared to 15.2% across the nation. 7 of the 10 states with the highest poverty rates are located in the South including MS (27%), AL (23%), LA (22%), AR (21%), SC (21%), TN (20%) and GA (19%). (SGPB, Profile, 1986)

HIGH RATES OF UNEMPLOYMENT PLAGUE SOUTHERN YOUTH

- 21.5 percent of southern teens (aged 16-19) were out of work in 1986. 39% of black and other minority teens in the South were unemployed compared to 16.3% of white teenagers. More than half of the non-white youth in LA, MS, TN, and AR were unemployed in 1986. (Bureau of Labor Statistics, [BLS], unpublished data)

LOW WAGE JOBS INCREASE IN THE SOUTH

- In 1983, 46% of Southern workers were employed in low-wage jobs as office workers (15%); service workers (14%); sales workers (11.9%); and unskilled workers (5.2%). This is an increase of 4.5% since 1978. Most of this increase came from the growth of sales workers. (SGPB, Recent Occupational Shifts in the South, August 1984)

* Women predominate in low-wage employment. 98% of office workers, 70% of service workers and 68% of all sales clerks in the rural South are female. (Southeast Women's Employment Coalition, [SWEC], Women of the Rural South, 1986)

RURAL AREAS LOSING JOBS FASTER THAN METROPOLITAN AREAS

* As a result of automation and global competition, 250 textile plants, most of them located in the rural South, have closed since 1980 and more than 100,000 textile jobs have been lost. (SGPB, Visions of the Future of the South, December 1985)

* Between 1977 and 1982, metro counties accounted for more than 80% of all the employment growth in the South even though they have only 68% of the region's population. (SGPB, After the Factories, December 1985)

* Between 1977 and 1982, manufacturing employment dropped as a percentage of total rural employment, from 55% to 26%. Service sector employment increased from 37% to nearly 60%. Other sectors of growth included mining (16% of total growth) and manufacturing in chemicals, plastics and rubber (8% of total job growth.) (SGPB, After the Factories, December 1985)

REAL EARNINGS IN THE SOUTH DECLINE

* Between 1978 and 1986, real weekly earnings in the South fell by 8.3%. (BLS)

* Full-time southern workers in 1986 earned, on average, $321.00 per week. Average weekly earnings for female workers were $264.00 compared to $385.00 for male workers. Black workers averaged $254.00 per week in 1986. (BLS)

* In 1980, per capita income in the rural South was $7,735 the lowest of any U.S. region. For blacks, per capita income was $3,203. (SGPB, Report of the Committee on Human Resource Development, 1986)

* 10.7% of hourly workers in the South earn the minimum wage or less. (National Council on Employment Policy, 1986)

HIGH SCHOOL DROP-OUT RATES INCREASE; HIGHER IN RURAL AREAS

* In 1985, 65.7% of persons in the South completed high school within 4 years compared to 68.8% in 1972. (U.S. Department of Education, State Education Statistics, 1985-1986)

* High school drop-out rates are higher in southern rural areas than in southern metropolitan counties. In 1980, half of the population aged 25 and over in rural areas of the South had high school degrees compared to 2/3 of all adults in metropolitan areas. (SGPB, Trends in Education, Spring 1986).

- 1 out of every 4 adults in the South (and 1 out of every 3 black adults) have less than an 8th grade education. (SGPB, Report on the Committee on Human Resource Development, 1986)

- As a result of lower high school graduation rates, fewer southerners enter college programs. Only 25% of persons in the South completed 1 to 3 years of college. 12.6% of southerners have completed 4 or more years. (Office of Educational Research and Improvement, U.S. Department of Education, Digest of Education Statistics, 1985-1986)

4/24/87

SUMMARY ON HEARING, "INFANCY TO ADOLESCENCE: OPPORTUNITIES FOR SUCCESS" WASHINGTON, D.C., APRIL 28, 1987

On April 28, 1987, the Select Committee on Children, Youth, and Families held a hearing entitled: "Infancy to Adolescence: Opportunities for Success." The hearing was held to examine the newest scientific evidence regarding the prevention of health, education and behavioral problems of childhood and adolescence as well as opportunities for enhancing children's well being.

David A. Hamburg, M.D., President, Carnegie Corporation of New York, New York, NY, began the hearing by presenting an overview of prevention opportunities at different stages of childhood. Beginning with the prenatal period, Hamburg emphasized the evidence from research of the positive effect on low birthweight rates and infant mortality attributable to quality prenatal care and adequate nutrition during pregnancy. After birth, the most effective and cost effective preventive measure is immunization.

During childhood, studies show that early education and child care have "profound potential" for ameliorating a variety of academic, health, and social problems experienced by children. Also, parent education has been shown to be effective in reducing injuries and accidents, a major health hazard for children.

Adolescence, noted Hamburg, is marked by a "testing of all kinds of possibilities." Peer-mediated programs designed to prevent the initiation of problem behaviors among adolescents, such as smoking, drinking, and taking drugs, have proven effective. Other promising approaches include comprehensive health care clinics in or near senior and junior high schools, and broad based (including media) education as a means to prevent substance abuse among the young.

C. Arden Miller, M.D., Professor and Chairman of the Department of Maternal and Child Health, University of North Carolina, Chapel Hill, NC, described the results of research comparing pre- and post-natal (perinatal) maternity services and family benefits in 10 European countries and the U.S. All of the study countries, including several nations marked by extreme poverty and ethnic diversity, had lower low-birthweight rates than the U.S. These lower rates were directly attributable to the vastly more extensive perinatal care systems in place in each of the 10 nations. The systems varied substantially in the method of financing, from completely private to predominately tax-based. However, unlike the U.S., in each nation, perinatal care was universally available, and national standards to ensure the quality of care were in place.

Miller also reported that rates of teenage pregnancy, abortion and child-bearing were substantially lower in the 10 European nations than in the U.S. Higher U.S. rates were not attributable to earlier onset of sexual activity, but to more limited access to sex education and contraceptives. Miller emphasized that reductions in childbearing rates among European teenagers occurred when medical and family benefits for pregnant women were expanding during the 1970's, indicating that teenagers were not induced "to increase their fertility in order to take advantage of benefits."

James Garbarino, Ph.D., President, The Erikson Institute for Advanced Study of Child Development, Chicago, IL, testified about prevention opportunities during early childhood (2 - 5). One area of opportunity is early education. According to Garbarino, early problems in school among at-risk children can be prevented by helping children become familiar with the "culture of literacy." "By providing literacy promoting activities, motivated parents and professionals can communicate the messages that children need to become fully conversant with the 'academic culture'. Thus prepared, they are ready to start school not as aliens....but as natives to that culture."

Garbarino noted effective strategies for preventing accidents and injury during early childhood such as tamper-proof bottle caps and automotive seatbelts. Programs of early relationship building between children and adults, as well as parent education and home health visiting have also been shown to reduce injuries due to assault in the early childhood period, including child abuse. He also emphasized the importance of high quality child care as a way of preventing the potentially harmful consequences of the "new demographics" -- the increasing number of single parent households and households where both parents work -- and as an essential element in any national prevention-oriented campaign aimed at early childhood.

Gilbert Botvin, Ph.D., Associate Professor and Director of the Laboratory of Health Behavior Research, Cornell University Medical College, New York, NY, provided testimony concerning strategies for preventing substance abuse among children entering adolescence. Botvin indicated that while traditional approaches to drug abuse prevention, which emphasize factual information about the adverse health, social and legal consequences of using drugs, have not proven effective, they continue to be widely used in schools and other child-serving institutions. New substance abuse prevention models have proven more effective, according to Botvin. These models teach junior high school students a range of life skills designed to enhance self-esteem and social competence, thereby reducing the potential motivations to use drugs. They also teach specific techniques for effectively resisting social influences (particularly peer pressure) to smoke, drink, or use drugs. The intent of these programs, Botvin explained, is to teach relatively general life skills that are applicable to a variety of situations, rather than being specific to one particular problem or situation.

Botvin said that over 20 studies show 30% to 75% reductions in new junior high school cigarette, marijuana, and alcohol users (compared to groups that received no treatment) using the new prevention techniques.

Robert A. Kenny, Ed.D, Associate, Harvard Graduate School of Education, Boston, MA; and Consultant to the Community of Caring and the Joseph P. Kennedy, Jr. Foundation, Washington, DC, described the "Community of Caring," a Kennedy Foundation program for pregnant adolescents. Begun in 1977, the program operates in 300 health and human service agencies across the nation, and recently in schools in New Haven, CT, and Los Angeles, CA. The program consists of an interdisciplinary curriculum on topics such as health and nutrition; avoiding risks (drugs and alcohol); sex, love and marriage; and avoiding harm (sexually transmitted diseases). The Community of Caring also attempts to create a supportive interpersonal environment that helps teenagers develop self-esteem, self-discipline, and responsible decision making concerning sex.

According to Kenny, Community of Caring participants, compared to pregnant teens generally: have a higher rate of returning to high school; have significantly reduced drug and alcohol abuse and child abuse, greatly reduced rate of repeat pregnancies, receive higher quality prenatal care, and have an infant mortality rate of near zero.

Richard Price, Ph.D., Director, Michigan Prevention Research Center, University of Michigan, Ann Arbor, MI, reported on an American Psychological Association Task Force on Prevention, which he chaired, to identify successful prevention programs. He identified the factors common to the most effective programs, including: 1) Target groups for whom there is a clear understanding of the characteristics that put them at risk, such as age, income, or minority status; 2) Change the life circumstance of the individual and alter their life course in a positive direction, rather than produce only a short-term gain; 3) Give people new skills to cope more effectively or provide support during a critical life transition; 4) Strengthen natural support networks and make use of resources from families and schools; and 5) Have collected rigorous research evidence of their success.

Price emphasized that rigorous research on prevention programs is expensive, time-consuming and absolutely essential if prevention programs for children, youth and families in the United States are to fulfill their promise.

SUMMARY OF FULL COMMITTEE HEARING ON "ALTERNATIVE REPRODUCTIVE TECHNOLOGIES: IMPLICATIONS FOR FAMILIES AND CHILDREN"

WASHINGTON, DC, MAY 21, 1987

The Select Committee on Children, Youth, and Families held a hearing to examine the legal, ethical, and health issues accompanying recent scientific advances in reproductive technologies. Among the issues explored at the hearing were the causes and incidence of infertility and current treatment techniques, equity issues for women and families, and the potential regulatory roles of federal and state government.

The first panel of witnesses began with testimony from Gary D. Hodgen, Ph.D., Scientific Director, Jones Institute for Reproductive Medicine, Professor of Obstetrics and Gynecology, Eastern Virginia Medical School, Norfolk, VA, who reviewed the most advanced infertility treatments currently in use. These include in vitro fertilization (IVF -- eggs are fertilized in a petri dish and implanted into a women's uterus), gamete intrafallopian transfer (GIFT -- egg and sperm are placed in the fallopian tube, where conception and early embryonic development occur in a normal manner); donor egg treatment (donated eggs are fertilized in vitro with sperms from the husband of the recipient, and the embryo is implanted in her uterus); and cryopreservation of embryos (freezing embryos created in vitro for later use).

IVF and GIFT are the most widely used techniques. By the end of 1987, 5,000 children worldwide and 1,000 in the U.S. will have been born using these methods.

Hodgen also reviewed two additional techniques that are currently under study: oocyte (egg) freezing, and fertilization of eggs by microsurgical placement of a single sperm.

Hodgen said that sound, basic research involving in vitro fertilization and other new technologies must continue in order to further develop safe, affordable infertility treatments and more effective methods of contraception which preserve subsequent fertility. He noted, however, that inherent in any such research are many serious ethical, legal and religious questions which require careful review by scientists, physicians and lay persons.

Robert J. Stillman, M.D., Associate Professor, Obstetrics and Gynecology, and Director, Reproductive Endocrinology and Fertility, George Washington University Medical Center, Washington, DC, testified that 15% to 20% of the married, reproductive age population are infertile. The frequency of infertility appears to be increasing because of problems associated with contraceptives, sexually-transmitted diseases, reproductive toxins, and delayed childbearing. About 40% of infertility experienced by couples is traceable to the female, 35% to 40% to the male, and 20% to 25% to multiple factors.

The costs of infertility treatment can vary significantly. The average cost of treatment is $2,500 to $4,000 for 4 - 6 months, although in vitro fertilization costs $3,500 to $4,500 per cycle and may require 3 or more cycles to succeed.

Fifty percent of all couples can be treated successfully with drugs and procedures before trying "alternative" technologies. Of those who cannot be treated in this way, Stillman estimated that 25% to 80% can benefit from in vitro fertilization.

Wendy Chavkin, M.D., Director, Bureau of Maternity Services and Family Planning, New York City Department of Health, testified that the new reproductive technologies should be considered in context: many Americans lack access to basic reproductive health services; 25% of American women receive late or no prenatal care; and infant and maternal mortality, especially for blacks, are higher in the U.S. than in many third world countries.

Rather than focusing on treatment for the one in six infertile American couples affected, Chavkin advocated the concentration of resources on the underlying causes of infertility, such as sexually transmitted diseases, inadequate contraception options, and environmental toxic exposures. In addition, effective parental leave and child care policies would reduce some of the financial pressures that lead some couples to delay childbearing, which tends to increase the risk of infertility.

Chavkin expressed concern that new reproductive arrangements, such as surrogate parenting, have led some to consider children as "commodities" and women as "breeders." By disallowing fees for eggs, sperm, uterus use, babies and brokers, she said, the risk of economic exploitation is reduced, yet medical innovation remains possible.

Chavkin further noted that alternative reproductive procedures are not covered by Medicaid, and are, therefore, not an option for poor families. She viewed this policy as inequitable and unsupportable. On the other hand, she recognized that federal funding of these procedures might divert scarce health dollars.

Richard Doerflinger, Assistant Director for Pro-Life Activities, National Conference of Catholic Bishops, Washington, DC, based his testimony on the Vatican's recent "Instruction on Respect for Human Life in Its Origin and on the Dignity of Procreation." This document urges that public policy regarding reproductive technologies be guided by two key principles: 1) a child's fundamental right to life from the time of fertilization; and 2) the integrity of marriage and the family.

Doerflinger said that abortion, discarding or freezing of embryos, and experimental manipulation of embryos violate the life and physical integrity of the newly conceived child. Also, the sanctity of the family can be eroded when relationships between husband and wife or between parent and child are blurred or redefined by some reproductive procedures. Of particular concern are methods which introduce third parties to aid in reproduction, which may enable children to have as many as five "parents". In such arrangements, the child is denied the right to a unified family, and the moral and legal responsibilities traditionally seen as inherent are diffused. Children are reduced to commodities for sale and the biological mother is exploited as a "surrogate uterus."

John A. Robertson, J.D., Baker and Botts Professor, School of Law, University of Texas, Austin, told Members that procreation by married couples is a constitutionally protected right, subject to state limitation only for compelling reasons and not merely to express distaste or moral condemnation. Infertile couples should have the same right to bear, beget and rear children that fertile couples do as long as there is no tangible harm to others. Therefore, banning or failing to enforce surrogate contracts would interfere with procreative liberty.

According to Robertson, the interests of donors and surrogates who attempt to renege on uncoerced contracts would not be a sufficient reason to abrogate them, even though their grief and pain are substantial. Nor could the state ban these contracts just to prevent the emergence of new forms of non-nuclear, blended or extended families.

The state could regulate entry into collaborative contracts to assure that donors and surrogates are well-informed and freely consenting, Robertson stated. The state could also regulate donor and surrogate transactions to protect the welfare of resulting offspring, including the preservation of records on the identity of third parties in case the child wishes to know its genetic and gestational history.

George Annas, J.D., M.P.H., Professor of Health Law, Boston University School of Public Health, began his testimony by "rating" various non-coital reproductive techniques in terms of the degree to which they are of concern to society and should therefore be regulated or discouraged. GIFT and IVF, for example, were rated as the least socially problematic, while surrogate embryo transfer and the use of frozen embryos present the most difficult social policy issues. Annas expressed particular concern at the potential use of new technologies to create embryos when infertility is not present.

Regulation of alternative technologies, which Annas contends is a matter of state concern, can be brought to bear on such issues as the quality of medical practice; control of human experimentation; identification and obligations of fathers and mothers; legal provisions for donor screening and record confidentiality; commerce in gametes and embryos; and attaching conditions to the delivery of medical services that are paid for by government programs.

Currently, while more than half the states have statutes making the husband of a woman impregnated through artificial insemination the child's legal father, no states have specific statutes on IVF, GIFT, or other new techniques. Annas asserted that states should define the gestational mother as the child's legal mother for all purposes. She may choose to give up her rights as mother, as in adoption cases, but should be able to retain the child despite prior contractual agreements.

Lori Andrews, Research Fellow, American Bar Foundation, Chicago, IL, testified that the use of alternative reproductive technologies should not be outlawed because there is no evidence that children created through these methods are damaged. Also, surrogacy is not "baby selling" because a child is not turned over to strangers, and there is no question about the child's security. Forbidding payment, Andrews argued, might lead to coercion of friends or relatives to act as surrogates. The state should, however, assure that the surrogate has given voluntary, informed consent and require the health care provider arranging the procedure to tell the potential participants (the couple and a surrogate) about the nature of the process, its risks and benefits, any alternative techniques that could be used, and the physician's or clinic's success rate.

Andrews contended that it would be hypocritical of the federal government to ban surrogacy or to ban paid surrogacy when the government itself has failed to adequately enforce employment discrimination laws and underfunded social service programs, contributing to the need for some women to consider this option.

Contracts establishing the legal parentage of children conceived through alternative means must be in place before pregnancy, Andrews told Members, and must be enforced. The surrogate mother should not be allowed an option to change her mind, because, unlike many adoption cases, the decision to relinquish the child was not made under the stress of an unwanted pregnancy. Also, if a surrogate were allowed to change her mind, it places the child in legal limbo and at risk of psychological stress during a protracted court battle.

Robert Marshall, Director, Castello Institute, Stafford, VA, told Members that birth control is responsible for the separation of intercourse and reproduction, and contributes to infertility, the use of abortion, sexual immorality and family breakdown. According to Marshall, birth control has historically been advanced by some groups as a means of eugenic control to remedy "feeble-mindedness, mental defect, defectives, paupers and other unfit."

Marshall contended that the use of amniocentesis to detect prenatal defects "usually amounts to a fetal search and destroy mission." Moreover, "unwanted babies have no rights and are morally equivalent to disposable property." Marshall added that surrogacy should be abolished, in part, because it exploits women and treats children as "chattel."

SUMMARY OF FULL COMMITTEE HEARING ON "PREVENTING OUT-OF-HOME PLACEMENT: PROGRAMS THAT WORK" WASHINGTON, D.C., JUNE 9, 1987

On June 9, 1987, the Select Committee on Children, Youth, and Families continued its examination of out-of-home placement in a hearing that focused on successful and cost-effective family preservation programs as means to strengthen families and prevent the removal of children from their homes.

Sondra Jackson, Program Manager, and Al Durham, Program Specialist, Intensive Family Services (IFS) Program, Department of Human Resources, Social Services Administration, MD, began the hearing by describing Maryland's model family preservation program, IFS, which is distinguished by a team approach, small caseloads, "flexible dollars," 90-day time limitation, specially trained staff, staff consultation with family therapists, and unlimited family contacts for the duration of a family's participation in the program. They stated that Maryland, like most states, has had to direct efforts towards child protection and placement, leaving limited resources for the development of prevention. At the same time, there has been growing recognition that foster care is not the solution to family problems and that protective services are inadequate to deal with overall problems of child abuse and neglect. The Maryland General Assembly provided $1.2 million for implementation of the IFS program in FY 1986. IFS staff positions are allocated to local departments of social services based on the foster care population.

The Maryland officials reported that families who participate in IFS show a much lower rate of out-of-home placement than do those who receive the traditional service delivery, both at entry into services and at termination. They estimate that the program saves $6.2 million in averted foster care costs for every 1000 children receiving IFS.

Martha, Deborah and Lisa, parents from Prince George's County, MD, next told the Committee about their own need for intensive services and how the assistance they received helped them improve their living circumstances and avoid removal of their children. Martha, who is married with six children and whose husband has mental health problems, told the Committee how the family was unable to pay bills, and were at risk for foster care because of crisis in their housing situation, with an immediate problem of having had utilities turned off. IFS helped the family to get utilities switched back on; assisted in getting child care for two of the younger children so that Martha could look for a job; helped an older son successfully apply for Job Corps; and is working to help Martha gain more control of family finances. Deborah was in jeopardy of having her 8-year-old son removed from home because of chronic neglect due to alcoholism. IFS has helped her define and confront her alcoholism. She now attends AA and is learning to control her alcoholism. Lisa was unskilled, unemployed and homeless with an infant daughter. IFS helped her get into low-income housing and job training. She also testified that the program assisted her in defining manageable goals for herself and her child, as well as raising her own self-esteem.

Judge John Tracey, Juvenile Court Judge, Montgomery County, MD; and Chairman, Permanency Planning Task Force, State of Maryland, testified that, with intensive intervention, the courts and social service departments can help troubled families early on, prevent out-of-home placement, and assist reunification if removal has occurred. He added, however that, while intensive preplacement prevention is valuable, sometimes out-of-home placement may be the only alternative, and good services are required to address the needs of these families as well. Often when families enter the system, according to Tracey, services are neither present nor accessible, especially for poor families. He called for a continuum of intensive family-based services that can help families who require different kinds of assistance. He also recommended centralization of services so that families could obtain the range of assistance they might need in one place.

Kristine Nelson, DSW, Senior Researcher, National Resource Center on Family Based Services; and Associate Professor, School of Social Work, The University of Iowa, Iowa City, IA, followed with an overview of family-based services and their common features. She noted that these services have grown tremendously over the last 10 years, accelerated by the mandates of P.L. 96-272. Shared goals are to maintain children in their own homes, to reunify families whenever possible, and to facilitate permanency in the least restrictive setting for children who cannot remain at home. Nelson cited results of evaluations which indicate that intensive services programs have 80-90% rates of success in preventing placement among families who receive services, as well as success in returning children from placement. Nelson reported that, according to a recent survey of family-based services workers, family empowerment, the view that most children are better off in their own homes, and goal-oriented services determined by families themselves, are of great importance in successful family-based programs. Common family-based program techniques include interventions aimed at the whole family, rather than individual members, traditional casework, parent education, and help with daily living problems. Nelson added that offering a wider range of services may distinguish highly successful programs from mediocre ones.

Nelson recommended federal funding of research and information dissemination projects, and greater federal monitoring to ensure that the states are properly implementing P.L. 96-272. She pointed out that family preservation services are still offered very unevenly, and often are triggered by placement rather than offered in advance. She called for federal funding of professional education and in-service training to assure a continued supply of skilled workers to provide intensive services. She also called on family-based services to broaden their scope to the variety of problems that may confront families, because all families at risk of separation can benefit from a family based services approach.

Frank Farrow, Director of Children's Policy, Center for the Study of Social Policy, Washington, DC, testified regarding ways to build family preservation services as an integral component of state child welfare systems. He described the Center's efforts to assist states reorganize and improve their child welfare programs in a way that prevents family disruption whenever possible, and assures that placement meets the child's needs and moves more rapidly toward permanency. He noted that, while the body of research on intensive family-based services is still small, "there is sufficient experience and evidence to suggest that, if these programs were applied on a more systematic basis within state child welfare systems, they could reduce rates of entry into foster care and assure more effective support to families caring for children at home."

Farrow added that the development of family preservation services has been uneven, with most new efforts consisting of pilot projects. Farrow expressed concern that services will be "layered on," rather than effecting systemic changes in the ways children and families are served. He highlighted several issues identified by states as critical to the successful implementation of family preservation programs, including: (1) achieving support for the philosophy of family preservation services; (2) establishing clearly the goals of the program(s) and target population; (3) clarifying the relationship of family preservation services to a full continuum of child welfare services; (4) developing procedures to preserve the quality of services in the face of pressures to divert the program from its initial goals; (5) organizing methods of financing to establish a secure funding base; and (6) designing effective evaluations.

Carolyn L. Brown, Ph.D., Director, Commonweal Family Services/ Full Circle Family Consulting Services, San Raael, CA, described the Commonweal Family Preservation Program serving families in which a child's learning disabilities and neurological problems have created and contributed to family disruption. Brown stated that increased environmental stress has caused an increase in biological and psychosocial vulnerability and disease in children and families. The program serves families in four San Francisco Bay Area counties. The program teaches parenting skills; supports families in gaining access to other services; and provides 24-hour, on-call services for a period of 6 to 8 weeks. It also offers a range of specialized diagnostic and consulting services. Brown reported that 75% of the families served by the Commonweal Program remain intact for at least 12 months after receiving services.

Brown concluded that, despite the humane and cost-effective nature of family preservation programs, in many parts of the country, including the San Francisco Bay Area, funding for these programs is not available. She suggested that part of the federal funds given to States for out-of-home placements should be earmarked for pre-placement family preservation services. At the state level, she recommended establishing a financial incentive for counties to utilize these services.

Monna L. Hurst, Regional Director, Virginia Department of Social Services, Fairfax, VA, presented testimony on behalf of Commisioner William L. Lukhard, Virginia Department of Social Services, Richmond, VA. She cited the serious and continuing needs of families today, asserting that what is required is concrete commitment to serving families with clear direction and accountability from the top to the bottom of the child welfare and social services system. She described Virginia's efforts to prevent out-of-home placement that began in the early 1980's with grants to private, non-profit agencies. Of 715 children in 319 families served under the grant program, only 7% were placed into foster care. Evaluation also showed that 69% of the families improved in overall family functioning during the projects, and that prevention services cost an average of $1,214 per child, compared to $11,173 to care for a child in foster care for 4.6 years (the state's average).

Hurst noted that the Department has set aside $225,00 in state funds and $500,000 in Social Services Block Grant funds to be allocated to local agencies to provide services that prevent placement. The Department also worked to change the definition of foster care in state statutes so that foster care funds may be used for pre-placement prevention. Hurst recommended that Congress support these efforts by continuing to authorize transfer of Title IV-E funds to IV-B in order to provide more services to families; and by reauthorizing the Child Abuse and Neglect Act and including therein funding incentives for state programs.

Ellie Stein-Cowan, Executive Director, Familystrength, Concord, NH, described the approach of the Familystrength program, its success in preventing out-of-home placement and the need to foster public/private partnerships that offer and support family-based services. The Familystrength program, begun in 1985, is designed to be family-centered, in-home, short-term, time limited and intensive. By September 1987, it is expected to cover 3/4 of the state and will serve 300-500 families per year. The program serves families presenting a broad range of problems, including alcoholism, sexual abuse, poor job skills, family violence, school problems, housing and food inadequacies, mental illness. District courts refer families in which a child is at risk of placement and where other community resources are not adequate. Stein-Cowan reviewed preliminary analysis of 1986-87 data showing that 76% of the participating families remained intact at the end of treatment; 12% had children placed temporarily and, with support, are expected to be reunified within several months; 12% required longer-term placement. The average cost of the intervention was $4,800 -- less than half the avarage cost of placement for one child for one year.

Stein-Cowan asserted that intensive services to high risk families cannot be successfully undertaken by private or public agencies alone, but must be taken on as a public/private partnership. Services involving only private agencies are often isolated and struggle in an unsupportive environment. Involvement solely by the public agency may mean working within a closed system without the benefit of independent professional perspectives. She cited the need for better evaluation and dissemination of information regarding family-based services. She added that states have the responsibility to establish standards for family preservation services; to identify points in child welfare decision-making where services can be applied; and to support legislative changes and targeted funding where necessary.

John H. Paschal, M.S., Program Supervisor, Florida Department of Health and Rehabilitative Services, concluded the hearing with a description of Florida's Intensive Crisis Counseling Program (ICCP). Based on Washington's "Homebuilders" Program, the Florida ICCP has been successful in keeping severely dysfunctional families intact through the use of sound crisis intervention and short-term, home-based therapy. Since its inception in FY 1980-81, the program has grown from 2 pilot projects to 11 ICCP projects serving almost half the counties in the state, with more expansion planned for next year. Each ICCP can serve about 110-115 families per year. Paschal reported that ICCPs serve families in which a child has been referred for abuse or neglect (60% of cases) or status offense behavior, and in which there is imminent danger of removing the child from home. Most families receive services for about 4 weeks (6 weeks, maximum), with daily visits in the first 2 weeks and twice-weekly visits thereafter. Paschal outlined key elements of successful programs, including the provision of specific social services (e.g., transportation or arranging for public assistance) with crisis intervention and short-term, family-based therapy; and timeliness, intensity and accessibility of services.

In 656 families terminated from the program between July 1, 1985, and March 30, 1987, 87.3% of the children had not been removed from their homes; follow-up data on 356 of these families showed that 61.8% of the children were still in their homes 12 months after termination of services. ICCPs also are viewed as contributing to reductions in the foster care population. Between 1976-1980, the average rate of children (per 1000 children under age 18) in care was 3.3; between 1981-85, this rate was 3.1; between April 1984 and March 1985, when the ICCP began operating statewide, the average rate of children in foster care declined to 2.6. Paschal added that, despite their success, the ICCPs are not without problems: the length of time to get started (up to 2 years) results in higher costs per family; inclusion of families which do not meet the criterion of being in imminent jeopardy of removal distorts accuracy of "success rates;" counselors may become enmeshed in the family, thereby exacerbating its problems rather than effecting change; and ongoing services are lacking upon ICCP termination, resulting in inadequate followup.

SUMMARY OF FULL COMMITTEE HEARING ON "AIDS AND TEENAGERS: EMERGING ISSUES" WASHINGTON, D.C., JUNE 18, 1987

The Select Committee on Children, Youth, and Families continued its examination of the implications of the spread of AIDS (Acquired Immune Deficiency Syndrome) on children and youth in a hearing, "AIDS and Teenagers: Emerging Issues," on June 18, 1987. To date, teenagers have largely been ignored in the widespread discussion of AIDS. And, while the number of reported AIDS cases among teenagers remains small, several indicators of adolescent behavior suggest that they can be at high risk of contracting the virus. This hearing examined the risks of AIDS to adolescents and efforts to educate young people about preventing its spread.

C. Everett Koop, M.D., Sc.D., Surgeon General, U.S. Public Health Service; and Deputy Assistant Secretary of Health, U.S. Department of Health and Human Services, opened the hearing with testimony about the risks of AIDS faced by adolescents, ways to educate them to prevent the spread of the AIDS virus, and current and anticipated federal education efforts. He called adolescents and pre-adolescents "those with behaviors we wish to especially influence because of their vulnerability when they are exploring their own sexuality and perhaps experimenting with drugs." He added that teenagers often consider themselves immortal, and as a result, may put themselves at great risk. Koop highlighted several indicators of risk to teens, including the large numbers of teens affected by sexually transmitted diseases each year; the approximately one million unplanned pregnancies each year, indicating not only the extent of which teens are sexually active, but also the extent to which they might transmit the virus perinatally; the fact that 80% of unmarried males and 70% of unmarried females report experiencing intercourse at least once by age 20; and the sharing of needles among those youth who inject drugs. Furthermore, he added, although the data demonstrate that many teens are at risk, most do not believe they are. Only 15% report changing their behavior because of concern about contracting AIDS; and only 20% of those who changed their behavior used effective methods.

Koop submitted that education about AIDS should begin at home so that children can grow up knowing what behaviors to avoid to protect themselves from exposure to AIDS, and that the Nation's schools have a vital role to play in assuring that all young people rapidly understand the nature of the epidemic, and specific actions they can take to protect themselves from becoming infected. He stated that education must go beyond the biology of the disease, its symptoms and consequences, and be designed specifically to help teenagers adopt the kind of behavior which will keep them from contracting the disease. He said that school education programs need to emphasize abstinence and that he believes that "it is possible to focus on pre-adolescent youngsters and produce a generation of teenagers who will remain abstinent until they develop a mature, monogamous relationship." During questioning, he explained further that adolescents who are already sexually active must be offered information on safer sex practices, including information on the proper use of condoms.

The Surgeon General also described for the Committee efforts undertaken by agencies of the Public Health Service (PHS), including the Centers for Disease Control, the Alcohol, Drug Abuse, and Mental Health Administration, Health Resource and Services Administration, and the National Institutes of Health, that focus on AIDS among teens.

Mary-Ann Shafer, M.D., Associate Professor of Pediatrics, Adjunct Professor of Health Policy, Associate Director of Adolescent Medicine, University of California at San Francisco, CA, began the second panel describing the risks of AIDS to adolescents based on what is known about incidence and prevalence of sexually transmitted diseases (STDs) and other risk factors for teenagers. She pointed out that, while abstinence from sexual intercourse is the most effective means to prevent AIDS, over one-half of 15-19 year olds are sexually active, and by age 19, over 70% of teens have become sexually active; use of condoms is an effective prevention strategy, yet only 20% of 15-19 year old girls state that they used condoms at last intercourse; sexually active teens have the highest rates of STDs among heterosexuals of all age groups, and STDs are the major health hazard of adolescents today; and more than half of the 20 million STD cases reported yearly will occur in individuals under age 25 (1/4 will be affected before graduating from high school). Yet, according to Shafer, health education interventions are non-existent or inadequate. Shafer told the Committee that, contrary to our general view that adolescence and young adulthood is a time of optimal health, 15-24 year olds comprise a group whose mortality rate (96/100,000) has not declined between 1960-1980. She stated that demographic changes, including increasing numbers of families living at or below poverty, will place more youth at risk for STDs, including AIDS. And, according to a recent study of San Francisco high school students, adolescents lack sufficient knowledge about the cause, transmission, and prevention of AIDS, particularly about the preventive measures that can be taken during sexual intercourse. Minority youth were about twice as likely as white youth to have misperceptions regarding AIDS.

Shafer recommended that interventions include information on attitudes about, and personal susceptibility to STDs and AIDS; be sensitive to cultural needs; and be immediate and sustained. She noted that one of the core objectives in PHS' "Promoting Health/Preventing Disease: Objectives for the Nation," is that "by 1990, every junior and senior high school student in the US should receive accurate, timely education about sexually transmitted diseases." She also recommended that Congress assume a greater leadership role in addressing AIDS, by setting up a National AIDS Committee; supporting a massive media campaign which includes the promotion of condoms among sexually active youth; assisting in the development of curricula and school programs especially in high HIV prevalence areas; and recognizing that subpopulations of adolescents including minority youth and youth in detention may be at particularly high risk and should be targeted for immediate and intensive intervention.

Louis M. Aledort, M.D., Professor and Vice Chairman of the Department of Medicine at the Mount Sinai School of Medicine, City University of New York; and Director of the Mount Sinai Hemophilia Center, New York, NY, reported that there are approximately 15,000 to 18,000 hemophiliacs under the age of 30 who require frequent human blood product replacement to prevent bleeding. AIDS was reported among hemophiliacs in 1982, and as of April 6, 1987, there were 327 patients diagnosed with AIDS, with 63 under the age of 19. Since 1985 the rate of newly reported cases has remained at about 30-37 cases per quarter making the hemophiliac population probably the most infected of all risk groups, with two-thirds reported to be sero-positive. Aledort explained that hemophiliacs continually face a chronic disease with attendant painful bleeding episodes and joint destruction, and now have the additional burden of AIDS infection and responsibility associated with the disease. Aledort noted that adolescents are risk-takers, and may not fully comprehend HIV transmission. Aledort emphasized that HIV-positive youths have the potential to expose an infinite number of other adolescents. A recent survey at the center showed that although 98% of their responding hemophiliacs have acquired the majority of facts about the transmission of HIV, 51% do not practice "safer sex."

Aledort described that, up to now, those caring for hemophiliacs have emphasized how similar to everyone else hemophiliacs could be with proper treatment. However, because of the density of the AIDS infection and risk in the hemophiliac population, hemophiliacs now need to be helped to recognize that they are different and learn to take responsibility because of their higher risk. Aledort called for health educators knowledgeable about adolescents to teach hemophiliac patients about safer sex techniques, and the development and support of adequate psychosocial support systems. Currently, most public and private insurers do not reimburse for these services.

Vernon H. Mark, M.D., F.A.C.S., Associate Professor of Surgery, Harvard Medical School, Boston, MA, testified that public policy to limit the spread of HIV must be based on compassion, suggesting federal health insurance or re-insurance for those health problems related to the HIV infection, and workman's compensation insurance for those people who lose their jobs because of discrimination on the basis of HIV infection. He suggested devising plans to treat infected drug addicts so that they will not spread the disease, noting that "one approach might be to quarantine their drug habit by giving them methadone or other narcotics under medical supervision."

Mark stressed that we should be concerned about the millions of presently uninfected Americans who are potential victims of HIV, as well as those already infected. He questioned the effectiveness of condom use for reducing risk of HIV infection, citing WWII military data on poor compliance with condom use, as well as a research which shows that condoms can reduce but do not eliminate risk of infection. He proposed that a primary focus be placed on identifying infectious individuals and called for: "repeated epidemiological HIV testing to see how far and into which groups of the population that the HIV epidemic is spreading; confidential mandatory and repeated testing of the high risk groups - with contact tracing; accountability of those people who are found to be infectious, to be certain that they don't pass the disease by sex or needle sharing to the uninfected."

Karen Hein, M.D., Associate Professor of Pediatrics, Department of Pediatrics, Albert Einstein College of Medicine, Bronx, NY, concluded the second panel emphasizing the special characteristics of the teenage population and the need for an interdisciplinary perspective in addressing issues of teens with or at risk of AIDS. She pointed out that, currently, AIDS cases are 93% male, but women, particularly young minority women, are increasingly expected to be carriers of the virus. When STD rates are recalculated based on the percentage of sexually active adolescents and adults in each age group, rates for teenagers are twice as high as young adults in their 20's. Important psychological and developmental factors that indicate risk to teens include the invulnerability that teens tend to feel, as well as the immediacy and power of peer pressure that can override abstract and distant risks. Hein also highlighted the potentially greater risks facing teens in metropolitan areas, especially in the northeastern section of the country where the prevalence of the AIDS virus is highest. The implications are grave for teens as well as for children they might bear, since pregnant teens can transmit HIV infection to their children. In New York City, 10% of the mothers of babies born with AIDS are young women under 21 years of age. Hein reported that the current low numbers and percent of adolescent AIDS cases reflect the cumulative, not the current pattern of infection, adding that it remains difficult to get an accurate sense of HIV prevalence in the adolescent population. Asymptomatic HIV infection in adolescents is likely to present as illness in young adults.

Hein commented that the difficult ethical and legal considerations related to testing, screening, informing partners and counseling are much more complex when considering minors. She also pointed out that, unlike the kind of cost analyses on care with adults, the cost of identifying and caring for adolescents requires analysis that goes beyond direct costs of testing and patient care. The usual barriers keeping adolescents from obtaining medical care (payment, consent and confidentiality) are particularly relevant in relation to HIV infection. Hein recommended that action plans be based on the assumptions that: 1) adolescents are a heterogeneous population socioeconomically, culturally, and developmentally; 2) to be effective, prevention must take place before widespread HIV infection in the adolescent population is detected by the presence of numerous cases of AIDS; 3) interventions must both include and go beyond traditional institutions.

Becky Adler, age 17, Teen AIDS Hotline, Rockville, MD, began the last panel of witnesses, describing her volunteer activities with the Teen AIDS Hotline, staffed by teens who are trained to provide information about AIDS and referrals to services, such as testing and counseling centers. She noted that sexual activity and behaviors that may place individuals at higher risk of AIDS often begin in the teenage years. She added that, while the teens who staff the hotline talk about high risk activities rather than high risk groups, she stated that, "if there is such a thing as a 'high-risk' group, it is teen America." The hotline operates 7 days a week, 8 a.m. to midnight, in English and Spanish and gets calls from teens as well as adults, asking for factual information about AIDS or asking for help. Adler reported that the hotline received over 4,000 calls in May. Adler also listed the several other programs sponsored by the group including teen and family conferences on AIDS, PTSA (Parent/Teacher/Student Association) AIDS nights, and a teen internship project with teens teaching teens about AIDS and how to protect themselves.

Jonathan T. Howe, President, National School Board Association (NSBA); and Past President, Northbrook School District #27, Northbrook, IL, stressed the importance of considering AIDS as a national health problem and the important role the school community has to play in disseminating information and prevention education. He stated that AIDS education cannot be an optional activity for schools but must be undertaken, because school-age students are a primary AIDS risk group. He cited a newly released study by the National Association of State Boards of Education showing that 24 states have or are developing AIDS curricula. Among them, Rhode Island and Kansas have mandated AIDS education, specifying grade levels for introduction of various topics. Howe said that educational materials should be developed by education professionals and health experts working together to assure that curricular materials are factually correct and age-appropriate, and that they provide responsible, comprehensive AIDS education. NSBA currently is providing materials to assist local school boards enact responsible policies in regard to students and staff members with AIDS, and to assist staff develop and make available the most current information on AIDS.

NSBA noted the following guidelines for curriculum development: materials should be simple, direct, in terms the students can understand, based on the most current information available, and sequentially tailored to students' level of development, both emotionally and intellectually; discussion of risks should emphasize high-risk behaviors, rather than high-risk groups; curricula should emphasize abstinence, but should include discussion of condom use as a method to reduce the risk of AIDS for those who are sexually active; curricula should address sexuality responsibly, consistent with community values.

Ms. Johnnie Hamilton, Science Coordinator, Fairfax County Schools, Annandale, VA, next reported that, during the last school year, 43,000 students in 22 high schools in Fairfax County participated in a formal AIDS education program. Hamilton said that, at the demand of parents and the community, the school system incorporated the AIDS curriculum into their course on Human Life Education. The curriculum includes the definition of high risk groups, how AIDS is transmitted, and prevention strategies. The community had an opportunity to review the curriculum. It was also intensely screened by an advisory group composed of PTA representatives, parents, clergy, health department officials, and teachers. Biology teachers are trained by public health nurses from the county health department, and others, to present the AIDS curriculum to students in 10th grade biology classes. Biology teachers also go into other classes in 9th, 11th, and 12th grades so that all students will receive the information. They plan to expand the curriculum to reach 7th and 8th graders next year.

Richard Gordon, Executive Director, Youth Development Branch of the Sequoia YMCA, Redwood City, CA, testified about the efforts of the YMCA in developing an AIDS education curriculum to work specifically with out-of-school, homeless, delinquent, and incarcerated youth. The Youth Development Branch serves 15,000 teenagers and their families annually in a juvenile court diversion program for delinquent offenders, two shelters for runaway youth, a drop-in center for homeless youth, and a long-term residential treatment center. These teenagers are more likely to be involved in sexual experimentation and drug use; may be involved in juvenile prostitution and drug sales; and if sheltered or incarcerated, they are often in same sex facilities where there may be increased homosexual activity or homosexual rape. In addition, the youth are often not in school where AIDS education of children and youth, if present at all, is aimed. The school dropout rate is 18% in San Mateo County, 31% in California; and, according to a study of youth in the state's runaway shelters, 50% for youth in the state's runaway shelters.

The YMCA's AIDS education and prevention curriculum, was tested on 150 youth, revised, and has now been presented to an additional 400 young people in San Mateo County's juvenile facilities. Gordon reported that the young people expressed anxiety about the disease and were very interested in getting factual information. The most common misperceptions were that the AIDS virus could be casually transmitted and that it only affects gay or bisexual men. Gordon reported that there have been fewer misinformed comments about AIDS and increased inquiries about the availability of condoms, especially from females. Forty-six staff have been trained and certified to provide the AIDS curriculum in San Mateo county. Gordon called for federal support of programs for adolescents who are not in school, and greater cooperation with local AIDS organizations to develop prevention education and standards for non-discrimination.

Wayne C. Lutton, Ph.D., Research Director, The Summit, Manitou Springs, CO, concluded the hearing stressing that AIDS is essentially an adult disease. He stated that AIDS "is not a disease that originated among children, nor is it a disease that is being spread by children to any noticeable extent." He challenged the Surgeon General's Report on AIDS, stating that it "contains a number of serious factual errors." Lutton further stated that a program of education and the widespread use of condoms will do little to halt the spread of the disease. He said that public schools should teach children that the only truly healthy sexual behavior is abstinence until marriage. He added that schools should not be a "party to approving behavior that is unhealthy, possibly illegal or may incur financial liability because of damages from disease."

AIDS AND TEENAGERS

FACT SHEET

AIDS AMONG TEENAGERS AND YOUNG ADULTS AND FUTURE RISK

* As of June 8, 1987, there were 148 cases of AIDS among 13-19 year olds (.4% of the total 36,514 reported AIDS cases). Of the total AIDS cases among teens, 41% are white, 37% are black, 20% are Hispanic, and 2% are all other races. There are 7687 cases among 20-29 year olds (21% of the reported AIDS cases), many of whom probably became infected as teenagers. (Centers for Disease Control [CDC], June 1987)

* Geographically, cases of AIDS among teenagers are clustered in New Jersey, New York, and Miami. (CDC, 1987)

* Of the 148 cases of AIDS among teenagers, 41 cases involve teens with hemophilia. This represents 11% of all hemophilia-related AIDS cases. Of the cases among 20-29 year-olds, 88 have hemophilia, (24% of all hemophilia-associated AIDS cases). (CDC, June 1, 1987)

TEENS AT RISK

* Sexual activity is a significant risk factor for contracting AIDS. Over 11.6 million teens (70% of girls and 80% of boys) have engaged in sexual intercourse at least once by the time they reach age 20. More than one million teenagers become pregnant each year. It is estimated that 1 in 7 teens currently has a sexually transmitted disease. (National Research Council, Risking The Future: Adolescent Sexuality, Pregnancy, and Childbearing, 1987; Quackenbush, Testimony before the Select Committee on Children, Youth and Families, February 1987)

* Sharing hypodermic syringes can also transmit the AIDS virus. Intravenous drug use is not that prevalent among adolescents, but it still remains a potential risk factor. In 1985, 1.2% of 16,000 high school seniors reported having ever used heroin. (Alcohol, Drug Abuse, and Mental Health Administration, 1986)

* More than 1/2 of the teenagers in a recent poll reported that they had had sexual intercourse by the age of 17. Only 1/3 of those who are sexually active said that they always use contraceptives; 27% say they never use contraceptives. (Louis Harris Associates, December 1986)

ATTITUDES ABOUT AIDS

* Nearly half (48%) of those Americans over the age of 13 interviewed in a recent Gallup poll are worried that AIDS will spread widely among the nation's teenagers. As to whether the fear of AIDS has affected the social life and dating habits of teenagers, 13% replied greatly, 43% replied to some extent, and 29% said not at all. Nearly 55% of the respondents said that birth control devices

should first be made available to 16-18 year olds; 31% said 12-15 years old. (Newsweek, February 16, 1987)

* A 1986 Roper poll of 8 to 17 year olds found that about 2/3 (65%) were personally concerned about the spread of AIDS: among teenagers 72% were greatly concerned and among children 58% were greatly concerned. (The American Chicle Group, Warner-Lambert Company, March 1987)

KNOWLEDGE ABOUT AIDS TRANSMISSION AND PREVENTION

* A survey of more than 1,300 students enrolled in Family Life Education classes at 10 San Francisco public high schools found that students possess some knowledge of AIDS, although this knowledge is uneven. With respect to disease transmission, 92% correctly indicated that sexual intercourse was one mode of contracting AIDS. 60% were aware that the use of a condom during sexual intercourse may lower the risk of getting the disease. (DiClemente, *American Journal of Public Health*, December 1986)

* Nearly 55% of the 860 16-19 year olds recently surveyed in Massachusetts indicated that they are not worried about contracting AIDS; 34% of the adolescents responded this way in the San Francisco survey. (Strunin and Hingson, *Pediatrics*, May 1987; DiClemente, 1986)

* In the Massachusetts survey, 70% of the teenagers said that they were sexually active but only 15% reported changing their sexual behavior because of concern about contracting AIDS, and only 20% of those who changed their behavior used effective methods to protect themselves. 8% did not know that AIDS may be transmitted by heterosexual intercourse. (Strunin and Hingson, 1987)

* In the same study, 13% of those responding reported using psychoactive drugs other than alcohol and marijuana and 1% reported injecting drugs. 8% of those reporting psychoactive drug use did not know that AIDS can be transmitted by injecting drugs. (Strunin and Hingson, 1987)

SCHOOL POLICIES ON AIDS

* A survey of 50 states conducted by the National Association of State Boards of Education [NASBE] shows that a majority of states (39) now have policies or a position statement on admitting students with AIDS to schools. However, fewer states (26) report that either curriculum materials or state standards on educating students about AIDS are already in place or are being developed. (NASBE, June 1987).

* This same survey reported that action on AIDS education policy is pending in 12 state legislatures, while only 7 states have an AIDS education policy already mandated. (NASBE, June 1987).

CENTERS FOR DISEASE CONTROL GUIDELINES**

* Assessment of the type of education and care setting appropriate for an AIDS-infected child should be based on

behavior, neurological development, and the physical condition of the child, and on expected type of interaction with others. This determination should be made by an interdisciplinary team.

* The benefits of an unrestricted setting for AIDS-infected school-age children outweigh the risks of exposure to harmful infection. Specifically, CDC recommends that these children should be allowed to attend school and after school day-care, and to be placed in a foster home, in an unrestricted setting.

* Mandatory screening as a condition for school entry is not warranted based on available data.

* All education and public health departments, regardless of whether AIDS-infected children are involved, are strongly encouraged to inform parents, students and educators about AIDS transmission and prevention.

* Persons involved in the care and education of HTLV-III/LAV-infected children should respect the child's right to privacy including maintaining confidential records. The number of personnel who are aware of the child's condition should be kept at a minimum needed to assure proper care of the child.

** (Excerpted from the Centers for Disease Control guidelines entitled "Education and Foster Care of Children Infected with Human T-Lymphotropic Virus Type III/Lymphadenophathy-Associated Virus", August 1985)

6/18/87

SUMMARY OF PREVENTION STRATEGIES TASK FORCE FIELD HEARING ON "FLORIDA'S ECONOMIC FUTURE AND THE CHILD CARE CRISIS FOR FAMILIES," MIAMI, FLORIDA, JUNE 22, 1987

On June 22, 1987, the Prevention Strategies Task Force of the Select Committee on Children, Youth, and Families held a hearing in Miami, Florida, to explore Florida's rapid economic growth and job expansion, the increasing number of young children and families, and the resultant demand on the state's child care system. The hearing also focused on the public and private sector's ability to respond to a potential child care crisis.

Prior to the hearing, the Committee conducted a site visit at the Miami-Dade Community College's Pre-School Laboratory, which provides a quality educational child care program for children ages 2 to 5, as well as an early childhood education and child care training facility for students. The program serves 67 children of students and faculty, as well as children from the community, with more than 400 children currently on the waiting list.

Ray Goode, a member of the Florida State Comprehensive Plan Committee; and President and Chief Executive Officer, The Babcock Company, Coral Gables, reported findings from the State Comprehensive Plan Committee including the extent of Florida's future population and economic growth and the anticipated demand on the child care system. Since 1980, Florida has averaged 893 new residents a day. Between 1975 and 1985, employment increased by 57%, and by the year 1995, employment will increase by another 36%. As a consequence, the need for additional child care placements is increasing. Currently, about 22,000 Florida children are on waiting lists for subsidized child care, and 50,000 children are waiting for openings in Head Start.

Marva Preston, Detective, City of Miami Police Department, explained how the Miami police department became involved in a criminal investigation of the death of two children, ages 3 and 4, who had been left at home alone. The police determined that their mother had done everything possible to find child care, but without success; and that she had been on a waiting list for the Title XX child care program for almost 2 years. According to Preston, the mother had no choice but to leave her children home alone to keep her job. The case was ruled an accidental death.

Susan Muenchow, Acting Executive Director, Governor's Constituency for Children, Tallahassee, testified that Florida is one of the few states that has increased funding for child care over the last several years. Muenchow described the state's efforts to increase the supply of child care including establishment of pre-kindergarten programs for disadvantaged 3-5 year olds; pilot school-age child care programs; and child care for children of teen parents at risk of dropping out of school. In the private sector, Muenchow reported that 90 businesses statewide offer some form of child care assistance.

Nevertheless, 25,000 children remain on the waiting list and it is expected that an additional 5,000 children will need subsidized care each year. Florida's supply of child care is especially inadequate for infants, but the major problem is that low-income families cannot afford the child care that is available. An additional $5 million appropriated for child care this year will be used to assist participants in Project Independence, the state's new welfare reform program.

Barbara Mainster, Chair, Florida Child Care Providers Forum; and State Program Coordinator, Redlands Christian Migrant Association (RCMA), Immokalee, testified that RCMA has been operating child care centers for rural farmworker families since 1965, and now serves over 3,500 children a year in centers and family day care homes. According to Mainster, agriculture is the second largest industry in the state and, in the next few years, the citrus industry is expected to expand by 1/3 into areas with even fewer child care services. Almost 14,000 new farmworkers, many of whom will be parents with children, will need child care. Mainster called for increased funding to keep up with the growth in the number of farmworker families needing child care.

Sarah Greene, Director, Manatee County Head Start, Bradenton, said schools, Head Start, and Title XX child care programs must coordinate their efforts to best serve the needs of working families. Greene recommended that 1) representatives from all groups should form a child care resource and referral service in each community; 2) services should be coordinated to prevent duplication and maximize dollars; 3) handicapped children should be mainstreamed whenever possible; 4) quality child care should be expanded in every county; 5) there should be uniform training in all areas of early childhood for all child care providers; and 6) a strong parental involvement program that provides training in child growth and development should be coordinated.

Guy Cooley, Director, Project Playpen, Inc., St. Petersburg, described his project, a network of 167 licensed family day care homes serving over 575 infants and toddlers in low-income families in Pinellas County. More than 582 eligible infants and toddlers remain on the waiting list. The project is supported partly by funds from the county Juvenile Welfare Board, a unique funding body independent of county government and mandated to support children and family programs through local taxes.

Project Playpen offers support services to its family day care providers, including free training and interest-free loans for home improvement. Lack of affordable liability insurance, however, has become a major barrier to recruiting new family day care providers. This is of particular concern since, within the past 6 years, the number of infants and toddlers in Pinellas County has grown 18% faster than the number of family day care slots.

Phoebe Carpenter, Executive Vice President, Community Coordinated Child Care for Central Florida, Orlando, focused on the need for child care, especially for single mothers, so that they can work. The United Way of Florida has shown that for every dollar the State of Florida spends on child care, $1.43 is recouped in sales tax that mothers who started working are able to pay. According to Carpenter, financial assistance for high quality child care allows families to become self-sufficient and provides for the healthy development of children, preventing more costly remediation later.

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Carpenter reported that the Title XX Social Services Block Grant has helped the State of Florida develop an organized and economical child care system. Eligible parents can choose the caregiver and the central administering agencies will pay a portion of the bill. The family contribution to the cost increases with their earning ability. If funds for this program were doubled, every eligible child in the state could receive child care services.

Mark Weaver, Personnel Manager, Philip Crosby Associates, Inc. (PCA), Orlando testified about his company's child care assistance program for its employees. The company pays 50% of an employee's child care costs up to $25 per child per week. PCA believes that companies will begin offering child care as a benefit to attract and retain employees in an increasingly competive job market, and that child care assistance improves employee productivity. Weaver reported that even employees who do not use the child care benefit appreciate that it is available.

Leonard Mellon, Executive Director, Florida Department of Highway Safety and Motor Vehicles, Tallahassee, told of the Department's on-site child care center for its state employees. The center was developed as a state demonstration. The center is self-supporting through parent fees, and half the families also receive Title XX assistance. The center operates at a limit of 75 children with a waiting list of over 200. Mellon believes public spending for child care is an investment in productivity and morale.

Gloria Simmons, Former Associate Director, Parent Resource Center/Crisis Nursery, Miami, testified about the 24-hour temporary child care provided by the crisis nursery for families at risk of abusing their children. In addition, the nursery program offers counseling, social services, medical screenings, clothing, parent education and meals at no charge. According to Simmons, the nursery has been effective in preventing cases of child abuse and neglect.

Almost 200 families voluntarily used the crisis nursery services during 1986; 22% because of eviction and 16% because they could not find housing. The fact that many of the families seek services because of housing problems is of particular concern given the rate of increase in the county's population.

Barbara Ibarra, Chair, Child Care Committee, City of Miami Commission on the Status of Women, Miami, focused on the need to assure that increasing numbers of working mothers will be able to continue working without having to worry about where their child will stay during the day. She also said that in Dade County alone, there are 9,000 children on the waiting list for subsidized child care, and an additional 4,736 children on waiting lists in general. By 1989, it is estimated that an additional 25,000 child care slots will be needed in Dade County.

The organizations she is involved with are actively working to educate the public and elected officials to better understand the child care needs of working families; to involve the private sector in supporting child care for their employees; to establish on-site centers for County employees; and to increase school involvement in the provision of after-school child care programs.

FLORIDA'S ECONOMIC FUTURE AND THE CHILD CARE CRISIS FOR FAMILIES

A FACT SHEET

FLORIDA'S POPULATION GROWTH ON THE UPSWING, INCLUDING MORE FAMILIES WITH YOUNG CHILDREN

* Since 1980, Florida has averaged 893 new residents every day, reaching a total of almost 12 million people in 1984. Between 1980 and 2000, the population is expected to grow by 80%. One analysis projects that Florida will soon become the third most populous state in the nation. (State Comprehensive Plan Committee [SCPC], February, 1987; Southern Growth Policies Board [SGPB], October, 1986)

* The population growth includes a high proportion of older people, but an even larger share is made up of mobile, working-age heads of households. (Speaker's Advisory Committee on the Future [SACF], March, 1987)

* By 1990, there will be almost 800,000 children age 0-4 in Florida, a 39% increase since 1980. The number of children ages 5-9 in Florida will reach 803,000 by 1994, a 17% increase since 1984. (Prevention Task Force, Florida Developmental Disabilities Planning Council, 1987; Florida Department of Health and Rehabilitative Services, [DHRS], Children, Youth, and Families Program Office, 1987)

FLORIDA'S ECONOMY BOOMS

* In the past decade, nearly 1.9 million new jobs were created in Florida. Between 1975 and 1985, employment in the state increased by 58%, more than twice the rate of increase in the nation. Only California and New York have experienced similar job gains. By the year 2000, total employment in Florida is expected to increase by 71%, or 3 million new jobs. (SCPC, 1987)

* Since 1977, Florida rose from 31st to 19th in the nation in per capita income. Between 1981 and 1984 alone, the per capita income rose by over 20% to $12,763. (SCPC, 1987; SGPB, 1986)

MANY CHILDREN AND FAMILIES LEFT OUT OF PROSPEROUS MAINSTREAM

* The percentage of Florida's children living in poverty increased from 17% in 1980 to 25% in 1986. (SCPC, 1987)

* Each year Florida's childhood population increases by nearly 60,000. Of these, 18,500 will live in poverty. (SACF, 1987)

* As of January, 1986, the maximum monthly AFDC benefit level for a family of 4 in Florida was only $298. (SGPB, 1986)

MORE CHILDREN IN WORKING FAMILIES, BUT CHILD CARE IN SHORT SUPPLY

- Approximately 782,000 of Florida's children ages 0-9 have working mothers and need some form of substitute care. (DHRS, 1987)

- The total number of licensed, registered, or officially exempt child care slots in the State still falls far short of the need. Currently, Florida licenses 4,086 child care facilities with a capacity for serving 302,189 children. In addition, approximately 2,600 licensed or registered family day care homes serve almost 15,000 children, not including 1,397 homes pending registration. Another 72,000 children are cared for in statutorily exempt child care facilities such as those with a religious exemption. It is estimated that 212,000 children are cared for in unlicensed or unregistered child care arrangements. (DHRS, 1987).

WAITING LISTS FOR CHILD CARE STATEWIDE

- Since 1981, Florida increased Title XX Social Services Block Grant expenditures for child care by 68% (from $26 million in FY 1981 to almost $44 million in FY 1986). Still, in February 1987, there were 23,610 children on the waiting list for subsidized child care in Florida. 32% of these children are from families on public assistance who are in training or employed. Over 8,000 on the waiting list are infants. (Children's Defense Fund, 1986; DHRS, 1987)

- In 1985, only 14,000 children participated in Florida's Head Start program; 50,000 low-income preschool children are on the waiting list. (DHRS, 1987; SCPC, 1987)

- Between 138,000 and 174,00 school-age children statewide are estimated to be "latch-key" children. (Association of United Ways of Florida, 1985; Personal communication, Latchkey, Inc., Pinellas County, 1987)

- The Early Childhood Development Association provides subsidized child care to over 2,600 children monthly in Broward County. Over 2,000 eligible children remain on their waiting list. (Early Childhood Development Association [ECDA], March, 1987)

- In Dade County, there are 4,736 children on waiting lists for child care, and an additional 9,118 children waiting for subsidized child care. By 1989, it is projected that 25,000 additional child care slots will be needed in Dade County. (Ibarra, 1987)

- Community Coordinated Child Care for Central Florida reports 2,500 children on their waiting list, almost as many children as are served by the program. (Community Coordinated Child Care for Central Florida, 1987)

- Project Playpen, which administers a network of more than 160 licensed family day care homes in Pinellas County, serves 575 children (167% increase in five years). They report that 582 eligible infants and toddlers are on their waiting list for subsidized care. During the past 6 years, the number of infants and toddlers in the county has grown 18% faster than has the number of family day care slots. (Cooley, 1987)

CHILD CARE SAVES MONEY

* In 1986, Florida saved $30 million in welfare payments by providing training, employment, and child care for nearly 22,000 dependent Floridians who were placed in jobs. (SCPC, 1987)

* Without affordable child care, parents may be forced to leave their children home alone, and may be adjudged as neglected by the courts. Foster care can cost $8,000 a year, compared to child care costs of $2,300 a year. (Levine in The Miami News, Nov. 20, 1986)

* A therapeutic preschool in Broward County serving abused children has documented that it costs $4361 per year to maintain a child in their program, but its costs $6,000 per year to maintain a child in foster care. (ECDA, 1986)

June 22, 1987

SUMMARY OF FULL COMMITTEE HEARING ON "AMERICAN FAMILIES IN TOMORROW'S ECONOMY" WASHINGTON, D.C., JULY 1, 1987

On July 1, 1987, the Select Committee on Children, Youth, and Families held a hearing entitled, "American Families in Tomorrow's Economy." This hearing examined current economic conditions as well as trends in the cost of health care, child care, housing, and education in order to assess future economic security for American families.

Frank Levy, Professor of Public Affairs, University of Maryland; and Guggenheim Fellow, Economic Studies, Brookings Institution, Washington, DC, began the hearing by pointing out that over the past 15 years, the proportion of children in poverty has risen from 14.2% to 21.0% despite an actual increase in per capita disposable income. According to Levy, these two seemingly contradictory trends could be reconciled if inequities in the distribution of income had also increased over this period. However, according to U.S. Census data, income inequality has not changed significantly since the 1940's -- except for families with children. Over the past 15 years, the bottom of the income distribution has reversed itself: the effect of indexing social security benefits to inflation enabled many elderly families to "move out" of the bottom of the income distribution while many female-headed families and two-parent families hurt by the 1980-1982 recession have moved in.

Although income per worker rose in the 1970's, real wages for individuals and families began to decline in 1973. Demographic trends, including increased female labor force participation, reduced family size, and delayed marriages, have enabled per capita income to increase despite declining wages. Beyond demographic adjustments, families have kept consumption standards rising by going into debt. Yet, not all families have had these choices. A single parent family doesn't have a second earner to send into the labor force. And husband-wife families displaced by the 1980-1982 recession have had to scramble to keep family income from dropping further.

Bruce R. Bartlett, Senior Fellow, The Heritage Foundation, Washington, DC, argued that the growth of the service sector has not led to a decline in the manufacturing sector nor has the decline in real wages over the past 15 years led to a shrinking of the middle class. In addition, he said that the distribution of income has remained extremely stable over the past 25 years.

The demand for services has grown rapidly in recent years in response to a maturing U.S. economy, not unlike the countries of Western Europe and Japan, Bartlett reported. On the surface, the move towards a service economy depresses average wages; in 1986, earnings in service sector jobs averaged $265 per week compared to $396 in manufacturing. Yet Bartlett indicated that these wage comparisons obscure the fact that higher-skilled and higher-paying service jobs in law, computers and advertising are growing more rapidly than lower-skilled ones.

According to Bartlett, the concentration of part-time jobs in the service sector -- 20% compared to 5% in manufacturing -- does depress average earnings. Yet, Bartlett suggested that since part-time work is the work schedule of choice, especially for mothers of young children, the growth of part-time jobs should not give policy makers cause for concern.

Cathy Schoen, Research Economist representing the Service Employees International Union (SEIU), Washington, DC, presented information from a new SEIU report indicating that both economic change and erosion of labor standards have produced a declining standard of living for American families. Given current trends, young men and women can expect to earn an average of 25% less throughout their lifetimes than the generation 10 years earlier.

Nearly 3 out of 4 people now work in public or private service jobs and industries, according to the SEIU report. Schoen argued that many service establishments -- including nursing homes, travel agencies, or fast food restaurants -- though small at the local level, are owned nationally by huge corporations. In fact, Fortune's Service 500 now rival the Fortune Industrial 500 in economic performance, profits and wealth.

Schoen pointed out that initially, the U.S. transition to service sector employment produced rising standards of living. However, new labor policies threaten to undermine all jobs. One out of 5 workers are now employed part-time; temporary employment has doubled since 1982; and nearly 2.7 million persons now work as independent contractors or employees of contract businesses. According to Schoen, 10% of union contracts now have two-tier wage scales with newly hired workers earning 30-35% less than older employees. Along with declining pay, jobs are losing basic benefits such as health insurance. The number of uninsured has increased 50% since the late 1970's and by 1986, 37 million persons under age 65 had no health insurance. More than three-quarters of this group are workers or their dependents.

Schoen suggested that the erosion of job standards, combined with off-shore production and a reduction in the value of the minimum wage, means that in today's economy, having a job is no longer an indicator of a family's ability to survive, much less achieve a decent standard of living. Schoen ended her testimony by arguing for new private and public polices to improve job standards: enactment of the Family and Medical Leave Act; increased funding for child care; guaranteed health benefits for workers; pay equity; and an increase in the minimum wage.

Sandra Hofferth, Health Scientist Administrator, National Institute of Child Health and Human Development, National Institutes of Health, Washington, DC, described supply and demand trends in child care as well as the cost of child care for families. By 1990, the number of preschoolers is expected to reach 23 million -- only slightly lower than the number of children under five at the height of the baby boom. The number of school-age children will also increase. And if current trends continue, by 1995, over three-quarters of school-aged children and two-thirds of preschool children will have a mother in the work force.

Hofferth indicated that mothers who work full-time are increasingly showing a preference for day care centers while part-time working mothers favor family day care homes. Day care centers have doubled their numbers since 1975. Demand for both center care and family day care is likely to increase yet questions remain as to the capacity of centers to care for growing numbers of infants and toddlers, according to Hofferth.

In the past 10 years, after accounting for inflation, expenditures on center care have not risen; family day care costs have risen slightly, and in-home child care costs have increased dramatically. Hofferth noted that over half of families who use a relative for care end up paying for that service, while 20% of families with an employed mother, many of whom also rely on relatives, do not pay for child care. For the 80% of families with children under 5 who do pay for child care, costs average $37 per week.

Nevertheless, child care expenses are a signficant component of family income, especially for low-income families. In 1985, families with a youngest child under 5 years of age spent 11% of their income on child care. Those with a youngest child age 5 years or older spent 9%. Low-income families pay a smaller total amount for child care than higher-income families, but they spend a larger proportion -- 20%-26% -- of their incomes on child care.

Carol Frances, Ph.D., Carol Frances and Associates, Washington, DC, presented information on cost trends and enrollment in higher education. College tuition has increased faster than either student or family income. Students are paying higher tuition because public support -- including both state appropriations and Federal student aid -- have not kept pace with inflation.

Frances argued that despite increasing costs, college enrollment, overall, has remained steady. In 1980, 12.5 million Americans were enrolled in college compared to 12.5 million in 1985. Over half of the new students during this period have been non-traditional students, aged 25-34 years. According to Frances, however, enrollment figures for blacks have dropped significantly while Hispanic enrollment (still only 4% overall) has increased 30%.

Grants and aid to college students have gone down, while educational debt has gone up. Between 1975 and 1980, federally supported student aid increased 70% while public tuition rates increased by 45%. However, between 1980 and 1985, federal student aid increased only 20% while tuition rates have escalated 65%. Almost half of all college graduates leave college with loans to repay bringing the total cumulative student loan debt to $75 million. According to Frances, a greater number of college students are combining paid work with education. Over 40% of full-time students work and almost 90% of half-time students are employed.

Deborah Chollet, Ph.D. Senior Research Associate, Employee Benefits Research Institute, Washington, DC, discussed trends in public and private health care coverage among non-elderly families. The number of uninsured people without health insurance grew by nearly 15% between 1982 and 1985 while the number of workers without coverage grew 22%. About two-thirds of the uninsured are children under 18 -- a 16% increase since 1982. By 1985, nearly 20% of all children under age 18 had no health insurance coverage from any source. Among children without health insurance, 20% lived with a parent that reported coverage from an employer plan. According to Chollet, the fastest growing group among the noninsured non-elderly are children of insured working parents.

As insurance coverage has declined, the cost of health care and health insurance has been increasing at an average annual rate of more than 9% -- faster than the cost of other consumer goods and services, and faster than average family income. Chollet indicated that since 1982, employers have reduced their contributions to family medical plans. In 1985, 54% of larger-establishment workers that participated in an employer health plan were required to pay all or part of the cost for dependents' coverage.

Chollet argued that the erosion of health insurance coverage among workers and their families can be traced to two related trends: the relative slow growth of employer-based coverage in a faster growing workforce; and a high growth in jobs that do not carry employer-based coverage, especially service sector jobs in medium and small-sized firms. The rising numbers of low-income, single parent families with children and the erosion of Medicaid coverage among low-income groups may also account for the growing numbers of children without health care coverage. According to Chollet, 2/3 of the uninsured live at or below 200% of the poverty level. And nearly 33% of single parent families with children who work year round are uninsured compared to 11.9% of two parent families with a full year worker.

Phillip Clay, Ph.D., Professor, Department of Urban Studies and Planning, M.I.T., Cambridge, MA, said that rates of home ownership have declined for the first time in 40 years. Between 1980 and 1985, home ownership rates among young families have declined, from 59% to 55%. The cost of housing has increased faster than families' ability to save, Clay reported.

Clay suggested that while declining real income is an important part of this problem, housing availability is the central issue. Housing demands have traditionally been met by new construction. In recent years, however, middle and upper income families have increasingly turned to older housing to meet their housing needs. As a result, low-income (often younger) families must now compete with middle-income families and single persons for older housing.

According to Clay, 12 to 14 million families currently live in substandard units while another 2 to 3 million people are homeless. Despite the rising need, the federal response to the housing crisis has been to decrease the number of assisted units of housing from more than 300,000 units per year in the 1970s to fewer than 100,000 per year. Additionally, Clay argued, tax cuts and tax reform have hurt efforts to provide affordable housing by reducing incentives to build rental units.

Clay recommended that a new national housing policy include: incentives to encourage construction of affordable private housing; increasing fair housing opportunities for families with children; and promoting community-based housing initiatives.

Allan C. Carlson, Ph.D., President, The Rockford Institute, Rockford, IL, agreed with Dr. Levy that families have sent more mothers into the workforce and reduced family size in order to cope with eroding wages. While the demand for child care and the high costs associated with it have strained family budgets, Carlson argued that the day care crisis should not be used as an argument for greater government involvement in American families. He contended that social experiments in other nations have shown that socializing health care, housing, or child care weakens the private family economy, restricts free choice, and increases government involvement in family life.

Carlson pointed out that in the 1940s through the 1960's, jobs paid a "family wage" -- enough money to care for the needs of the entire family. The family wage, combined with government tax breaks such as personal exemptions and housing mortgage deductions, enabled mainstream American families in the 1950's and 1960's to have one earner in the marketplace and another parent at home to care for children. Declining wages in the 1970's have changed all that for American families, Carlson said.

In order to "save the family," Carlson suggested that Congress should focus on tax credits and deductions to enable families with children to keep more of their earned income. Four steps could be taken: 1) increase the personal exemption for dependent children to $4000; 2) transform the existing child care tax credit into a universal credit with a set level -- $500 per child to a maximum of $1500. (This would be available to all families with children under 7 years of age regardless of whether or not they use day care); 3) transform the Earned Income Tax Credit into a universal Dependent Child Credit of $600 up to the total value of a parent's payroll tax; and 4) provide an additional dependent child credit of $600 to families in the year of a child's birth or adoption. Carlson recognized that family-oriented tax reform would mean a $30 to $40 billion loss of federal revenues, but argued that this could be offset by implementing the proposals incrementally or by raising taxes.

AMERICAN FAMILIES IN TOMORROW'S ECONOMY

A FACT SHEET

FINANCIAL PRESSURES ON FAMILIES MOUNTING

- * Between 1973 and 1984, mean real income declined for families with children by 8%, compared to a 13.5% increase between 1967 and 1973. Between 1973 and 1985, mean real income for married couples without children increased by 7%, and income for single individuals rose by 12%. (Joint Economic Committee [JEC], November 1985; U.S. Census Bureau, 1986)

- * Between 1973 and 1985, the percentage of working married mothers with children climbed by nearly 1/3, from 40% to 52%. The loss in family income for the average two-parent family would have been more than 3 times as great during this period if mothers had not gone to work. (JEC, May 1986)

- * The minimum wage, which in the 1960's and 1970's provided a family of 3 with enough income to escape poverty, now falls $2,100 short. A full-time, year-round worker earning the current minimum wage will bring home $6,968 a year, only 77% of the estimated 1987 poverty threshold of $9,044 for a family of 3. (Center on Budget and Policy Priorities, 1987)

INEQUALITY INCREASING IN THE DISTRIBUTION OF INCOME AMONG FAMILIES WITH CHILDREN

- * Between 1973 and 1984, inequities in the distribution of income in the U.S. have increased. The proportion of families with incomes over $50,000 increased from 14.9% to 15.6%; the proportion of families with incomes below $20,000 increased from 32.1% to 36.4%; the proportion of families with incomes between $20,000 and $50,000 fell from 53.0% to 47.9%. (Bradbury, 1986)

- * Throughout the 1950's and 1960's, the poorest 1/5 of families included 15% to 17% of the nation's children. By 1984, the poorest families contained 24% of all children in the U.S. (Levy, 1987)

- * Poverty among families with children has risen significantly in the 1980's. Between 1979 and 1984, poverty among all persons in families with children increased 37%, from 12.7% to 17.4%. Among two-parent families, poverty rose from 7% to 10.6%, or by 51% percent, while poverty among female-headed, single-parent families rose from 42.2% to 48.2%, or by 14%. (JEC, November 1986)

- * Income inequality in the U.S. is much greater than in other Western countries. Child poverty in the U.S. is 60% higher than the rate in Great Britain, nearly 80% higher than the rate in Canada, and more than double the rate in West Germany, Norway and Sweden. This is despite the fact that U.S. workers have higher average incomes than workers in any of these countries. (Burtless, 1987)

FAMILIES BORROWING MORE MONEY TO MAKE ENDS MEET

- 65% of U.S. households are in debt and 55% owe more than they own in financial assets. (Polin, 1987)
- In 1985, the level of household debt relative to disposable income reached a postwar high of 88%. (Polin, 1986)
- Between 1970 and 1983, the debt-to-income ratio has increased 83% for families in the lowest income quintile and 30% for families in the second lowest quintile. (Polin, 1987)

EMPLOYMENT TRENDS THREATEN ECONOMIC SECURITY

- Between 1978 and 1984, 37% of new jobs paid less than $8700 a year in 1984 dollars, compared to 27% between 1963 and 1978. (Working Women Education Fund, 1986)
- Between 1968 and 1985, part-time employment has grown faster than full-time work, registering a 40% growth rate versus a full-time employment growth of 32%. (Nardone, 1986)
- 28% of all part-time workers earn the minimum wage compared to 5% of all full-time workers. (Levitan and Shapiro, 1986)
- Between 1984 and 1995, the majority of occupations with the largest expected job growth include cashiers, janitors, nursing aids, waiters and waitresses, and retail sales clerks. (U.S. Bureau of Labor Statistics [BLS], 1985)

PROVIDING A HOME INCREASINGLY DIFFICULT

- In 1978, the typical home buyer had to make a down payment of about 1/3 of his or her household income; by 1985, the share had risen to 50%. (Joint Center for Housing Studies [JCHS], MIT, 1986)
- For an average 30-year-old male in 1973, the median priced home would have absorbed 21% of monthly pay; in 1984, the median priced home absorbed 44% of his monthly income. (JEC, December 1985)
- After steadily climbing for decades, the rate of home ownership has declined during the 1980's. Hardest hit are younger households; between 1981 and 1985, ownership rates for householders under 25 years of age declined by about 16%, for householders 25 - 29 by 10%, and for householders 30 - 34 by 8%. (JCHS, 1986)
- The median rent burden (rent plus heating payments) increased from 20% of household income in 1970 to 29% in 1983. The share of households with rent burdens below 1/4 of their income dropped from 60% in 1974 to 40% in 1983. The share of households with rent burdens above 75% of income rose from 8% to 13%. (JCHS, 1986)
- In 1983, the median rent burden for households in the lowest income quintile had risen to 46% of income, up from

35% in 1974, and in 1983 over 1/4 of the households in this group had rent burdens above 3/4 of income. (JCHS, 1986)

- Given current demographic and housing trends, between 1983 and 2003, the total number of low-rent units in America is projected to fall from 12.9 million to 9.4 million, a 27% loss. During the same period, the total number of households needing low-rent units is projected to increase from 11.9 million to 17.2 million, a 44% increase. (Clay, 1987)

CHILD CARE: THE NEW "BIG TICKET ITEM" FOR FAMILIES WITH CHILDREN

- Half of all married mothers with infants are in the workforce -- a 108% increase since 1970. 54% of married mothers of children under 6 are in the labor force, up by 80% since 1970. (SCCYF, 1987)

- In 1985, 68% of female single parents worked, up from 60% in 1973. (JEC, November 1986)

- By 1995, 2/3 of all preschool children will have mothers in the workforce. 4 out of 5 children between the ages of 7 and 18 are expected to have working mothers. (National Institute for Child Health and Human Development, [NICHD], 1986; Marx, 1987)

- The median weekly cost for child care in 1985 was $38.00. The proportion of total family income consumed by child care costs is 10% for non-poor families and 20% for families in poverty. Estimated annual child care expenditures by U.S. families are about $11.5 billion. (U.S. Census Bureau, 1987; Hofferth, 1987 [in preparation])

HEALTH CARE COSTS FOR FAMILIES INCREASE, ACCESS BECOMES MORE DIFFICULT

- Today, health care costs consume 10.9% of the total U.S. Gross National Product. By the year 2000, this proportion will grow to 15%. (Department of Health and Human Services, Health Care Financing Administration [HCFA], 1987)

- Health care expenditures are projected to triple between 1986 and the year 2000, from an average of $1,837 per person to $5,557. (HCFA, 1987)

- Costs for health care continue to outpace increases in personal income. Personal health care expenditures as a fraction of personal income grew from 11.2% in 1985 to 11.6% in 1986. If personal health care costs had grown at the same rate as personal income, consumers would have had $13.6 billion more to spend on other goods and services. (HCFA, 1987)

- An estimated 38.8 million Americans report they need health care but have trouble obtaining it. For almost 19 million Americans, the barrier to access is financial. (Robert Wood Johnson Foundation, 1987)

- In 1986, 36.9 million Americans had no private or public health care insurance, a 31% increase over 1980. (U.S. Census Bureau, Current Population Survey, 1980 and 1986)

- * The fastest growing population without health insurance is children of working parents with employer-based health coverage. (Employee Benefits Research Institute, [EBRI], 1987)
- * In 1985, nearly half of uninsured children age 18 or under lived in single parent, usually female headed, families. ([EBRI], 1987)
- * 1/3 of the U.S. population with family incomes below the poverty level are uninsured. 1/4 of the population with family incomes between 100% and 150% of the poverty line are uninsured. (Sulvetta and Swartz, 1986)

EDUCATION COSTS OUTPACE INFLATION

- * During the 1970's, college tuition for all institutions grew at an average annual rate of 6.6%, a lower rate than consumer prices, 7.8%. In the 1980's, college tuitions have grown by 9.8%, twice the rate of inflation. (American Council on Education, 1987)
- * College tuition costs are expected to rise by 6% per year in public institutions and by 7% per year in independent institutions in 1987-1988 and in 1988-89. Increases in inflation during this period are projected to be no higher than 4.5%. (Henderson, 1986)
- * Between 1978 and 1983, college participation rates declined among students with family incomes under $20,000 (in constant 1983 dollars), while participation increased for students from families with incomes over $30,000. (Lee, 1986)
- * The average total award (grants, loans and work study) per full-time equivalent student for all Department of Education programs declined from $2,200 in 1975-76 to $1,800 in 1983-84 (after adjusting for inflation). (The College Board, 1984)

July, 1987

SUMMARY OF FULL COMMITTEE HEARING ON "CHILDREN'S MENTAL HEALTH: PROMISING RESPONSES TO NEGLECTED PROBLEMS" WASHINGTON, D.C., JULY 14, 1987

The Select Committee on Children, Youth, and Families held a hearing in Washington, DC, to examine the nature and extent of childhood mental illness, the current response to children's mental health needs, and innovative programs and policies designed serve emotionally disturbed youth and their families better.

Glenda Fine, parent, Director, Parents Involved Network Project, Philadelphia, PA, opened the hearing by describing her difficulties in trying to get help for her son, Joshua, who first showed signs of disturbance at age 2-1/2 after the death of his father. By the time Joshua was 13-1/2, after numerous treatments and diagnoses and little help from the county mental health system, Fine had exhausted her financial and emotional resources. Since the county had no specialized support services to keep Joshua at home nor any residential treatment facilities, Fine was forced to give up custody of her son so that he could receive subsidized treatment.

Fine also noted the experiences of a 6-year-old who was excluded from school because of emotional problems and hyperactivity. Although P.L. 94-142 (Education for All Handicapped Act) is supposed to ensure that all handicapped children (including the seriously emotionally disturbed [SED]) receive appropriate special education services, SED children are often excluded from public school programs, or given only a few hours of homebound instruction each week.

Fine stressed that mental health services for children are frequently unavailable, coordination among child serving agencies is minimal, and there is usually no plan to determine who should be responsible for serving a particular child.

Jean Gaunt, specialized foster parent of emotionally handicapped children, Indianapolis, IN, related the experience of a child named Jason, whom the local school labeled "emotionally disturbed." The Gaunts had to move because services were so limited in their school system. At age 9, Jason was labeled "learning disabled" and was found to have a psychosomatic reaction to being sexually abused. Now 10, Jason is receiving counseling, yet problems continue. For example, Jason was recently placed in an emergency shelter after being found wandering around by the police. He is also a "fire starter."

Another child once in Gaunt's custody, Ricky, was passed between 4 foster homes, 5 temporary shelters, and 3 adoptive placements in his first 10 years. At age 12, Ricky sexually molested his sister and subsequently began 7 institutional placements in locked facilities. Two residential placements and 2 emergency shelter placements also followed. Throughout his childhood and through all of these placements, Ricky received minimal counseling. Now 18, Ricky will be released from the court's custody, even though he has been diagnosed as a threat to others.

Leonard Saxe, Ph.D., Associate Professor, Director, Center for Applied Social Science, Boston University, Boston, MA and principal author of Office of Technology Assessment (OTA) report, "Children's Mental Health: Problems and Services," testified that the majority of children with mental health problems fail to receive appropriate treatment, according to the OTA report. Many of the 6 to 8 million children in need of mental health interventions receive no care; perhaps 50% receive inappropriate care. The main reason children receive inappropriate care, Saxe said, is that treatment decisions are driven by the health care reimbursement system, which often forces hospitalization even when less restrictive, less expensive and more effective treatment methods and settings are more appropriate. The current approach is neither controlling costs nor providing adequate care. Children are often "dumped out" of the hospital before they are well enough to go home and without follow-up treatment because of limitations on insurance.

Saxe said that we do not spend enough on the mental health needs of children, and what we do spend is used inefficiently. He proposed a system that makes services available at the earliest stage possible, and one not based on labeling a child's psychopathology. Saxe described a demonstration program at Ft. Bragg, North Carolina, which is expected to show that 800 children can be served with the same amount of money now being spent to provide primarily inpatient care to less than 200 children by making available more appropriate treatment in less restrictive settings.

Saxe stressed the importance of establishing children's rights to mental health treatment, parallel to the provisions of P.L. 94-142 that guarantee children's rights to education.

Jane Knitzer, Ed.D., Director, Division of Research, Development and Policy, Bank Street College of Education, New York, NY, began her testimony by reviewing the 4 major findings from her 1982 report, Unclaimed Children: 1) At any one time there are 3 million seriously emotionally disturbed children, but only 1 million receive services and these are often inadequate. 2) Policy attention to the needs of emotionally disturbed children and adolescents is virtually nonexistent. 3) Those program approaches that seem to be responsive to troubled children and their families are few and far between and are usually financially precarious. 4) Unlike many other groups of children with handicapping conditions, emotionally disturbed children are largely unclaimed by the states, the federal government and advocates. Knitzer also said that there is little interagency coordination -- it is more a matter of chance which agency actually serves a particular child.

While many of these findings are still true, Knitzer mentioned some improvements since 1982, for which she largely credits the federal Child and Adolescent Service System Program (CASSP). These improvements include a movement toward systems of care in some states and communities; new resources channeled into children's mental health in others; and greater parental advocacy. However, these developments are fragile and only skim the surface of need. They are threatened, as well, by the great increase in for-profit psychiatric hospital beds for adolescents and by reimbursement patterns and state funds that still reward removing children from their homes (e.g., Medicaid is only available for the most restrictive treatment). Moreover, there is still no mandate to provide comprehensive services to emotionally disturbed children. Knitzer recommended that funding and mandates to provide a range of services for children be put in place; that schools play a greater role in meeting the mental health needs of children, and that more attention be focused on the needs of at-risk and younger troubled children.

Robert Friedman, Ph.D., Director, Research and Training Center for Improved Services for Seriously Emotionally Disturbed Children, Florida Mental Health Institute, University of South Florida, Tampa, FL, told the Committee that, at any point in time, 14-19% of youth may have a moderate or severe emotional disturbance, 5-8% have pervasive problems and less than 5% of children have emotional problems that are seriously handicapping, pervasive and persistent. Several efforts to plan children's mental health services in the public sector have been based on the assumption that 1-2% of children may require services at any point in time. Friedman contends that even when using this low percentage our public system has failed to reach effectively the children most in need.

A 4-year, ongoing longitudinal study of over 800 seriously emotionally disturbed children in 6 states who are receiving at least some publicly funded services has found that conduct disorder was the most common diagnosis (60%), with over 1/2 of these children also being diagnosed as depressed or anxious. Over 70% of all the children in the sample had multiple diagnoses.

Friedman spoke of a growing consensus about the need for an overall system of care that is interagency community-based, family-focused, and balanced between the most and least restrictive services with the flexibility to meet individual needs. Within most states, though, such services have not been developed. Instead, most funding for children's mental health services is spent on more costly residential placements, which are frequently far from a child's community. Barriers to a more balanced, community-based system of care include a lack of clarity about responsibility for disturbed youth, inadequate cooperation among child-serving agencies, and fiscal incentives and reimbursement policies that favor residential treatment.

Friedman advocated continued support of CASSP, research and training centers, and interagency activities on behalf of emotionally disturbed children. He also called for a strengthening of the Education for All Handicapped Act, since less than 1% of school children are identified and served as "seriously emotionally disturbed."

Stuart McCullough, Director, Contra Costa County Department of Mental Health, Contra Costa County, CA, led the next panel. He testified that reductions in the state mental health system, cuts in state hospital savings, and the transfer of responsibility for mental health to the counties under then-Governor Ronald Reagan led to a community mental health system in California that began underfunded and has continually operated on a poverty basis. In Contra Costa County, as around the state, the mental health system is seeing a growing number of referrals of increasingly disturbed children from all economic and racial backgrounds. Many of these children are violent, have a poor prognosis and come from very dysfunctional families. Some children are placed on adult inpatient wards because no other programs will accept them.

Caseloads among all the agencies in Contra Costa County that serve children are high. For instance, the typical juvenile probation officer carries a caseload of up to 80 children. Each of the 3 outpatient clinics in the county that serve children has a waiting list of at least 50 children. According to McCullough, the county works on a "triage" basis, serving the most self-destructive or imminently hostile children first. More than ever, other County Departments are asking the Department of Mental Health for assistance in carrying out their respective mandates.

In California, over 9,000 children are placed in group and specialized foster homes at an annual cost to the State of over $220 million. This expense is rising by 20% per year. McCullough called for an increase in funding for the children's mental health system and a focus on strengthening families.

Marilyn Mennis, Vice President, Philadelphia Child Guidance Clinic, Philadelphia, PA, told the Committee that the number of emergency room visits by children and adolescents to the Clinic is expected to exceed 1000 by the end of the year, as compared to less than 200 such visits in 1982. Half are suicide-related, involving children as young as 9. These children are more disturbed than youth 5 years ago, more are from "non-nuclear" families, and many are poor.

The Clinic set up several programs to reduce the number of admissions to community and state hospitals, including the Social Rehabilitation Program, in which a trained clinician spends 10-50 hours per month providing intensive, home-based therapy for the client and family, and assisting with housing, education, judicial and other problems that may aggravate family tensions. Of the 100 children and adolescents served during the program's first year, many of whom had previously been hospitalized at least once, none had to return to the state hospital; only 8 were hospitalized in acute care settings. Mennis also described the Host Home Program, jointly funded by Social Welfare and Mental Health, which places seriously disturbed children who cannot stay at home but who do not require institutionalization in the care of trained foster parents. The child receives therapy while in the foster home, and the natural family is kept involved in the child's treatment.

These programs are highly cost-effective: a year at the state hospital in Pennsylvania for one emotionally impaired child costs over $100,000 as compared to $6,000-$7,000/year for the Social Rehabilitation Program and $35,000/year for the Host Home Program.

Bert L'Homme, Executive Director, City Lights, Washington, DC, testified next about his community-based, educational, vocational, and therapeutic program for delinquent adolescents who are either at risk of being institutionalized or who are returning from such settings. The typical student is a 16-year old, emotionally disturbed, delinquent, black male, who reads and computes below the 3rd grade level. All are D.C. residents, where 44% of all the students who entered 9th grade in 1986 will not graduate, where 4,000 juveniles are apprehended each year, and where only 27% of black teens are working (as compared to 48% of white teens).

L'Homme also described "The Workplace," a school to work transition program. This program provides a full remedial education, complete clinical services, job placement and monitoring, and follow-up for $10/day/student. A follow-up study of youth who had attended City Lights revealed that those who attained a higher level of independence and were in less restrictive settings had grown up in one long-term foster home, had regular and SYEP work experience, were likely to be depressed rather than character-disordered, and read and computed math above the 5th and 6th grade levels, respectively. While City Lights cannot make up for all deficits, it has been able to positively influence work experience, attendance, and math and reading scores.

Thomas L. Davis, Mental Health Program Manager, Alexandria Mental Health Center, Children's Services, Alexandria, LA, spoke next about the mental health needs of rural children. He pointed out that low population in rural areas makes it difficult financially to justify specialized children's services, which, in turn, makes it hard to recruit mental health professionals, given the low pay available. Residents in rural areas also tend to underutilize available services because of transportation difficulties, time lost from work and school, and the stigma associated with mental illness. As a result, many children are not served in a timely manner, if at all.

Children's Services, part of a state-wide network operated by the Louisiana Department of Health and Human Resources Office of Mental Health, provides outpatient mental health, consultation and education, and school-based consultation and treatment services for severely emotionally impaired children, as well as a therapeutic summer day camp and a community home for emotionally disturbed adolescent boys. Only 19 of the 312 children admitted to Children's Services were recommended for psychiatric hospitalization in 1985-86.

Randall Feltman, MSW, Program Manager, Ventura County Mental Health Services, Ventura, CA, described the Ventura Model, a demonstration program initiated in 1984 to develop and evaluate a comprehensive local children's mental health system. The Ventura Model mainly serves children and youth with serious emotional disturbance who are either separated or at risk of separation from their families. Since family unity and local treatment are the primary goals, home-based and local programs which maximize parental responsibility have been developed. Less restrictive and intrusive alternatives to out-of-home placement and hospitalization are provided to serve children more appropriately and reduce costs. Mental health services are integrated with home, school, juvenile justice, and social services to address all of the children's needs. All new programs now blend services, staff and funding across agencies; parallel services have been eliminated.

After 18 months of operation, according to Feltman, the project has lowered the rate at which children are separated from their families and enabled many to return to their homes and schools sooner, offsetting more than 50% of its costs. For example, since June 1985, out-of-county, court-ordered juvenile justice and social services placements have dropped 46%; state hospital use has been reduced to 25% of its 1980-81 level (with an annual average savings of $428,000, which could save California $17 million/year in state hospital costs if expanded statewide); and reincarcerations have been reduced 47%.

Judith A. Shanley, Assistant Commissioner, Erie County Department of Mental Health, Buffalo, NY, concluded the hearing by noting the severe shortage of mental health services for children. In Erie County, as many as 28,000 children are believed to be in need of mental health services annually, but only 6,000 were served in 1986. The number of children presenting for psychiatric admission in the county hospital emergency room has doubled between 1986 and the first 6 months of 1987. These children appear to be more violent, younger, more likely to use drugs and alcohol, and more seriously disturbed with multiple problems. Also, they are far more likely to be from single parent homes.

Shanley cited the lack of coordination among service providers as the primary barrier to adequate mental health services. In fact, the goals for a child of one agency can be directly contrary to the goals of another. The Erie County Child Mental Health Consortium was developed to coordinate services better in Erie County, but Shanley said that a lack of significant agency commitment to this consortium is thwarting its purpose.

Shanley noted that there is no real mental health system directed especially toward children, and most training opportunities do not require training that takes into account children's mental health issues. Finally, Shanley said that reimbursement mechanisms are too inflexible, leading to inappropriate care for many children.

CHILDREN'S MENTAL HEALTH: PROMISING RESPONSES TO NEGLECTED PROBLEMS

A FACT SHEET

MILLIONS OF CHILDREN SUFFER FROM MENTAL HEALTH PROBLEMS

* From 7.5 to 9.5 million children in the U.S. -- 12 to 15% of those under 18 -- suffer from a mental health problem severe enough to require treatment. (Office of Technology Assessment [OTA], 1986)

* During the 1985-86 school year, 376,943 emotionally disturbed children aged 3-21 -- less than 1% of the total school population -- received services under the Education of the Handicapped Act. (U.S. Department of Education, 1987)

* 70% to 90% of runaway and homeless youth in the New York City area have emotional problems. 30% are depressed or suicidal; 18% are antisocial; and 41% are a combination of these. 50% of the children have been abused by their parents. (Shaffer, 1984)

* The most common childhood psychiatric disorders include: depression (between 5-10% of youth, with a threefold increase in the frequency of depression from childhood to adolescence) [National Institute of Mental Health (NIMH), 1987]; conduct disorder (about 4-10% of youth; prevalence appears to be at least three times more common among boys than girls) [Melton, 1987]; eating disorders (an estimated 1% of high school and 3% of college age women are anorexic; 5-10% of that population are bulimic) [NIMH, 1987]; attention deficit disorder/hyperactivity (an estimated 3-5% of the school-age population) [NIMH, 1987]; autism (about 5 out of 10,000 children; an additional 10 out of 10,000 children have related behavioral problems) [NIMH, 1987]; psychosis (an estimated 0.23% of youth) [Gillmore, Chang, & Coron, 1983 cited in Melton, 1987]; suicide (nearly 1,900 teenagers, aged 12-19, took their own lives in 1984) [Select Committee on Children, Youth and Families, 1987].

SERVICES FOR CHILDREN WITH MENTAL HEALTH PROBLEMS LARGELY UNAVAILABLE

* An estimated 70-80% of emotionally disturbed children get inappropriate mental health services or no services at all. (OTA, 1986)

* Less than 1%, or 100,000 children, receive mental health treatment in a hospital or residential treatment center in a given year, and perhaps only 5%, or 2 million children, receive mental health treatment in outpatient settings. (OTA, 1986)

* Shortages exist in all forms of children's mental health care, but there is a particular shortage of community-based care, case management, and coordination across educational, judicial and other child serving agencies. (OTA, 1986)

- Nationwide, there was a 13.5% shortage of special education teachers for the emotionally disturbed during the 1984-85 school year. (U.S. Department of Education, 1987)

THOUSANDS OF CHILDREN PLACED IN RESTRICTIVE SETTINGS, OFTEN INAPPROPRIATELY

- A 1980 survey of 1/3 of the nation's public and private hospitals found an estimated 81,532 persons under age 18 were admitted to inpatient psychiatric units. Approximately 95% of these children and youth were between the ages of 10 and 17, 53% were males, and 82% were white. (Jackson-Beeck, Schwartz & Rutherford, in press)

- A 1983-84 National Inventory of Mental Health Organizations estimates that about 26% of patients under 18 were served in private psychiatric hospitals, while 5.8% were served in state and county mental hospitals. (NIMH, 1986)

- State hospitals absorb about 70% of state mental health dollars. (Frank & Hamlet, 1985)

- Studies suggest that at least 40% of the hospital placements of children are inappropriate. Either the children should never have been admitted to the institutions or they have remained too long. (Knitzer, 1982)

- Juveniles tend to be admitted for less serious and less precise mental health and drug/alcohol disorders than adults, and their average length of stay is twice as long. For example, in 1985, the average length of stay for juveniles admitted for neurotic disorders was 23 days, as compared to less than 11 days for adults with the same diagnosis; and the average length of stay for juveniles admitted for nondependent use of drugs and alcohol was 23.4 days, as compared to 12.5 days for adults with this diagnosis. (Jackson-Beeck, et al, in press)

- Despite a decline in the population of 10-to-17 year olds in the Minneapolis/St. Paul Metropolitan Area of Minnesota, admissions of juveniles to hospital psychiatric units increased 25% between 1977 and 1985. This increase may not reflect any increase in the numbers of teenagers with psychiatric problems, but rather a means of dealing with "problem" youngsters. (Jackson-Beeck, et al, in press)

WHITE, MINORITY CHILDREN TREATED IN DIFFERENT SETTINGS

- Non-white youth are twice as likely to be hospitalized in state and county hospitals as white youth. (Truitt, 1985)

- In a three-state survey of residential treatment, over 70% of youth in "health" facilities were white, while the majority of youth in "justice" centers were from minority groups. About 1/2 of youth in public facilities but only 1/4 of youth in private centers were nonwhite. (Government Accounting Office [GAO], 1985; Krisberg, Schwartz, Litsky, & Austin, 1986)

- Of 824 Florida youngsters in residential placements in 1984, 50% of those in Florida training schools and 33% of those in the adolescent units at the state hospital were black; in contrast, only about 20% of the children in the other placement sites were black. (Friedman and Kutash, 1986)

MENTAL HEALTH CARE FOR CHILDREN INCREASINGLY FOR PROFIT

* In 1966, 7.6% of the 145 psychiatric facilities for children and youth in the U.S. were operated for profit; by 1981, 17.1% of 369 facilities were operated for profit -- a 125% increase. (Office of Juvenile Justice and Delinquency Prevention, 1983)

* Between 1980 and 1984, admissions of adolescents to private psychiatric hospitals increased an estimated 450% -- rising from 10,764 to 48,375. (National Association of Private Psychiatric Hospitals, 1985)

* A survey of state certificate-of-need agencies showed that proprietary interests now account for about 2/3 of applications for child and adolescent mental health/substance abuse programs. (Scalora & Melton, in press)

FEDERAL SUPPORT FOR TROUBLED YOUTH LIMITED

* In FY 87, $509 million was appropriated for the Alcohol, Drug Abuse and Mental Health Block Grant [ADMBG], of which approximately 50% went to mental health services. In 1985, a 10% set aside for new mental health services for severely disturbed children and adolescents was amended to include underserved populations, such as the homeless and the elderly, diminishing the focus on children. A GAO survey of 13 states found that some states chose not to fund children's services at all with the 1985 set aside. (Congressional Research Service [CRS], 1987; GAO, 1985 cited in OTA, 1986)

* Since the Community Mental Health Centers Act was repealed in 1981 and folded into the ADMBG, funding for mental health services has dropped from $277.6 million in FY 81 to $248 million in FY 87. (CRS, March 1987)

* In FY 85, 20.9% ($49.6 million) of NIMH's budget was spent on children and youth-related activities. (NIMH, 12th Annual Report on Child and Youth Activities, FY 85)

* NIMH's clinical training program has been cut 85% over the past 7 years -- from $70 million in 1980 to $15 million in 1987. Of that $15 million, only $3.3 million is used for training child mental health professionals. (American Academy of Child and Adolescent Psychiatry, May 1987)

* Although NIMH commits approximately 20% of its current research budget to children's issues, available dollars have not kept pace with assessments of the funds necessary. (OTA, 1986)

* In FY 86, the federal Child and Adolescent Service System Program (CASSP) spent $4.7 million to help 28 states and 3 localities develop a comprehensive, integrated system of

care for emotionally disturbed children and adolescents. (NIMH, 1987)

COST-EFFECTIVE PROGRAMS IMPROVE CHILDREN'S MENTAL HEALTH CARE DELIVERY

* Between 1981 and 1986, Florida's multi-agency network for severely emotionally disturbed students, SEDNET, reduced both out-of-state and out-of-region placement by 50%, despite a 28% increase in identified youth. (Clark, 1987)

* Ventura County Mental Health Demonstration Project, which provides an interagency system of care for the most needy children, has reduced state hospitalization by 25%, saving an average of $428,000 annually, reduced out-of-county, court-ordered treatment placements by 46%, reduced re-incarcerations by 47% and has saved the state millions of dollars. (Ventura County Children's Mental Health Project, 1987)

July, 1987

SUMMARY OF FULL COMMITTEE FIELD HEARING ON "EATING DISORDERS: THE IMPACT ON CHILDREN AND FAMILIES" SAN FRANCISCO, CALIFORNIA, JULY 31, 1987

The Select Committee on Children, Youth, and Families held a field hearing in San Francisco, CA, to examine the extent of anorexia nervosa and bulimia among adolescents, and the emotional, physical, and social effects on families and communities. Successful prevention and treatment programs, as well as research and health delivery system needs, were also examined.

Prior to the hearing, the Select Committee toured the in-patient eating disorders clinic at Marshal Hale Memorial Hospital where the hearing was held. Clinicians described for Members their comprehensive treatment program, its outcomes, and typical patient and family characteristics and concerns.

Krista Brown, age 17, Santa Rosa, CA, shared how her desire to be happier, more popular and less self-conscious led to anorexia nervosa. Over-exercising and starving herself gave Krista a false sense of control. Krista described how she withdrew from family and friends, refusing to cooperate with treatment until her weight dropped to a life-threatening 78 lbs. The inpatient eating disorders program at the Mt. Diablo Medical Center in Concord, CA, helped her deal with difficult feelings and to improve family communication.

Krista told the Committee that, in the 5 months since she left the hospital, she's the happiest she has ever been. Her experiences with anorexia helped her to build an inner self and the strength to approach obstacles without hurting herself. Krista stressed the deadliness of eating disorders, pointing out that without heightened attention to this problem, "many young girls are going to end their lives with an obsession."

Krista's mother, Susan Brown, testified about why Krista may have developed anorexia and how the illness affected their family. She described her daughter as quiet, shy and cooperative, one who took care of everyone else but herself. A well-intentioned diet begun when Krista was 13 turned into a ritualized pattern of living. All attempts to get Krista to eat were futile and Brown became desperate as she saw her daughter "dying right before [her] eyes." An initial hospitalization failed to help Krista, who Brown described as a "driven time bomb ready to explode."

Brown said that the illness made her family confront issues it had previously denied, leading to personal growth. The hardest thing she has had to accept, though, is that there is no cure for anorexia; it can only be controlled.

Laurel Mellin, MA, RD, Director, Center for Adolescent Obesity, School of Medicine, University of California, San Francisco, CA, described the extent of obesity among children and adolescents and its relationship to disordered eating. Obesity affects 27% of children and 22% of adolescents, a 54% and 39% increase, respectively, in the last 15 years. Mellin outlined the risk factors for obesity, including physical inactivity among children; a rapidly changing, poor quality food supply; dieting and pursuit of thinness as a national obsession, especially among girls (dieting can lead to binge eating, which in turn leads to obesity); gender role instability; a focus on external indicators of worth; and irresponsible advertising.

Mellin said that characteristics associated with eating disorders are pervasive among young girls. Her study of nearly 500 female children and adolescents showed that 80% of 10-year-olds were dieting and about half feared becoming fat and engaged in binge-eating episodes.

According to Mellin, 46% of families with obese adolescents are "chaotic" due to mothers' increasing presence in the workplace, fathers' failure to pick up the residual half of parenting, employers' insensitivity to the needs of families, lack of enriching after-school programs, and marital changes.

Mellin advocated treatment programs for obesity that emphasize healthful eating and exercising, rather than the current commercial programs which often lead to eating disorders or weight gain.

Joel Yager, M.D., Medical Director, Adult Eating Disorders Clinic, Professor of Psychiatry, Neuropsychiatric Institute and Hospital, University of California, Los Angeles (UCLA), CA, testified that anorexia nervosa is 2-4 times more common than it was several decades ago and that bulimia, more common than anorexia, appears to be rising in incidence as well. Conservatively, 1-5% of high school and college women have clinical eating disorders. At UCLA, 5% of students had clinical eating disorders and 20-40% of sorority women reported eating disorder symptoms. Yager also noted that as many as 7-14% of ballet dancers are affected by anorexia. A survey Yager conducted through *Glamour* magazine, to which 30,000 women responded, revealed that while most women fell within recommended weights, 75% felt fat and only 20% said they were not ashamed of their bodies.

Social pressures, such as the pressure to be thin, are most influential on those with low self-esteem, those who value themselves only for external achievements or appearance, and those with a tendency toward depression, alcohol and drug abuse, and impulsivity.

Yager stipulated that the biological role is unclear, but brain and hormone differences may exist among women who will or will not develop an eating disorder. Bulimia may be more likely to develop in families where parents have other emotional problems. Also, the majority of patients with bulimia suffer from depression and other psychiatric problems. According to Yager, in 60-70% of patients, anorexia nervosa is chronic, and 10-20% of patients may die of suicide or malnutrition. However, the earlier treatment begins, the better one's chances are of recovery.

Yager stressed that many families lack adequate health insurance and suggested that eating disorders be considered a catastrophic illness since treatment may require several months of costly hospitalization. He also called for prevention programs in elementary and junior high schools and funding for research.

Patricia Fallon, Ph.D., Clinical Psychologist, Seattle, WA, concurred with Yager that anorexia nervosa and bulimia have reached alarmingly high rates in women (90-95% of eating disorders occur in women) and that they appear to be on the increase. Fallon discussed the cultural factors that contribute to eating disorders, including an increasingly thinner body ideal for women and gender role conflicts. New research by Fallon found that 66% of nearly 190 bulimic women had a history of physical or sexual abuse.

Fallon said that dieting, fueled by a $5 billion weight loss industry, has become a national pastime for women and has been shown to directly precede the onset of an eating disorder. While all women are exposed to the same cultural pressures, not all develop eating disorders. The family has a major impact on whether rejection of unrealistic expectations occurs.

Fallon recommended continued support for detection and prevention of abuse, and education in schools and for families about the harmful effects of dieting.

Hans Steiner, M.D., Assistant Professor of Psychiatry, Director, Eating Disorders Program, Children's Hospital at Stanford, CA, testified that the mortality rate of anorexia is 5-20%, among the highest of any psychiatric disorder. Internationally, there has been a 2-4 fold increase in anorexia cases since the 1930's. Among female adolescents, 0.5-1% are anorexic, and 1-3% are bulimic. Steiner's own patient population has doubled over the past 6 years. Steiner challenged the idea that eating disorders are restricted to white, upper middle income families: at the Stanford program, 35% of bulimics are lower to middle income; 25% qualify for MediCal; and a large number are first generation Americans (13.8% Chicano and 8% Asian).

Steiner explained that without confirmed knowledge of the causes of eating disorders, treatments are often nonspecific. With individual, family, group, and inpatient psychotherapy, and behavioral, cognitive and drug therapy, 30-40% of patients recover in 4 years; 30% continue to be mildly symptomatic; 20% remain moderate to severe; and the rest worsen.

Steiner recommended more funding for research and education for pediatricians and in schools.

Joel Killen, Ph.D., Director, Adolescent Health Project, Stanford Center for Research in Disease Prevention, Department of Medicine, Stanford University, CA, focused on the need for prevention of eating disorders. He noted that overconcern with weight and dieting is pervasive. Killen's research has shown that 1/3 of 10th grade females judged themselves to be overweight when in fact their weight was within normal limits; 22% of the females reported frequent dieting; 30% said they dieted occasionally; and 10% engaged in total fasts. Killen also found that binge eating and purging occurs among substantial numbers of younger children and adolescents: 9% of 9 and 10-year-old girls in one study reported some purging behavior; 10.6% of 15-year-olds vomited to control weight, 8.3% used diet pills, and 6.8% used laxatives. Teenagers with bulimia also reported higher levels of substance use and depression.

Killen said that dieting, which only produces temporary weight loss and may undermine subsequent weight loss and/or lead to disordered eating, is the disorder we should be trying to cure. He described potential models for prevention, including instruction on healthful weight regulation. Primary prevention programs may teach adolescents how to recognize and resist social influences that promote unhealthful weight regulation, similar to those designed to prevent smoking. Programs for younger children are also needed, since the precursors of eating disorders are occurring earlier.

Linda Zimbelman, MA, MFCC, Psychotherapist, Hermosa Beach, CA, on behalf of the National Assocation of Anorexia Nervosa and Associated Disorders (ANAD), Highland Park, IL, testified that an estimated 7 million women and at least 1 million men of all ages, races and economic means have an eating disorder. She reported that an ongoing study by ANAD of thousands of students in over 470 high schools across the country indicates that eating disorders are epidemic. Children as young as age 5 have also been reported to ANAD.

Zimbelman agreed that dieting, low self-esteem, coping with stress, a cultural obsession with slenderness and sexual abuse are among the factors which lead to eating disorders.

According to Zimbelman, the federal government allocates tens of millions of dollars each year for other addictive syndromes, but devotes relatively little funding to eating disorders. Zimbelman urged increased funding for support groups and education/prevention programs, such as those provided by ANAD.

Vincent Moley, MFCC, Senior Research Associate, MRI; Director, Eating Disorders Center, Palo Alto, CA, emphasized the importance of a family focus for understanding and treating eating disorders, which have long-lasting negative effects on self-esteem and productivity. Rather than blame families, Moley uses them as agents for change by helping them to either stop perpetuating the disease or challenge unhealthful social pressures. He also teaches families how to resolve conflicts effectively.

According to Moley, prevention is also best accomplished within the context of the family. He espoused education of primary care physicians, school personnel and religious organizations in the early detection and intervention of eating disorders. Research on healthy families and on the way in which most women avoid eating disorders is also needed.

Michael Strober, Ph.D., Associate Professor of Psychiatry; Director, Adolescent Eating Disorders Program, Neuropsychiatric Institute and Hospital, UCLA, CA, concluded the hearing by saying that eating disorders, more insidious than alcoholism, are as baffling to clinicians as they are horrifying to patients and their families. While accounts of anorexia and bulimia date back 300 years, research suggests a rising incidence in the U.S. and in Europe.

Strober characterized the social factors believed to heighten risk among vulnerable individuals as the clash between competitive achievement and traditional female roles; attitudes toward emotional expression and sexuality; and familial effects on self-esteem. Sociocultural preferences toward a thinner body shape for women may also contribute to the development of eating disorders. Personality traits, such as compliancy and emotional reserve coupled with self-doubt and low self-esteem are consistently seen in anorexic patients, Strober reported, even after normal body weight is restored. The personality of bulimics appears to vary although traits of self-doubt and impulsivity are consistently described. The control of body weight is experienced as a means of restoring self-worth and compensating for other perceived inadequacies.

Family environments in which there is poor conflict resolution, emotional over-involvement or detachment, or lack of expressed emotion may increase the risk. Bulimia tends to be more strongly associated with hostile family interaction, and increased incidence of familial alcoholism and obesity. Eating disorders also appear to run in families. The presence of depression may increase the risk of eating disorders, but only if other risk factors are present.

A biological cause to eating disorders has not yet been determined; instead, many physiologic abnormalities are secondary effects of starvation, binge eating or purging.

Strober reiterated that anorexia is frequently a chronic illness that is resistant to treatment, especially if intervention is delayed. Strober maintained that while treatment of anorexia requires time, patience and specialized expertise, there are very few resources available to families and insurance is inadequate to cover the necessary cost of prolonged treatment.

EATING DISORDERS: THE IMPACT ON CHILDREN AND FAMILIES

A FACT SHEET

Anorexia nervosa -- a syndrome of extreme weight loss, body-image disturbance and an intense fear of becoming obese -- typically begins in early to late adolescence, although it can start any time from prepuberty to the early 30's. Bulimia -- a syndrome of binge-eating episodes followed by self-induced vomiting, fasting, or the use of diuretics or laxatives, typically begins between the ages of 17 and 25.

MILLIONS OF ADOLESCENTS, YOUNG ADULTS AFFLICTED BY EATING DISORDERS

- An estimated 1 in 200 teenagers ages 12-18 are anorexic; 90% of those affected are female. (National Institute of Mental Health [NIMH], 1987)
- Anorexia and bulimia together affect as many as 10-15% of adolescent girls and young women; estimates of the prevalence of bulimia among college women range as high as 19%. (Health and Public Policy Committee, American College of Physicians, [HPPC-ACP], 1986)
- In a recent national poll, about 2 million women ages 19-39 and 1 million (12%) teenage girls reported some symptoms of bulimia or anorexia. Four percent of teenage boys claimed to have had symptoms of either bulimia or anorexia. (Gallup, November 1985)
- In a 1985 survey of 1,728 10th graders, 13% reported purging behavior. Female purgers outnumbered males 2 to 1. (Killen, Taylor, Telch, Saylor, Maron, & Robinson, 1986)
- A survey of 907 college freshmen and seniors found that 8% of the women and 0.7% of the men were clinically bulimic. 23% of the women and 14% of the men reported eating binges at least once a week on average. (Zuckerman, Colby, Ware & Laxerson, 1986)
- Ballet dancers ages 12-21 report characteristics of anorexia nervosa significantly more often than controls and frequently use weight reduction strategies, such as fasting, binging, and selective food restriction. 50% of dancers, as compared to 20% of controls, weighed 80% or less of expected weight. (Braisted, Mellin, Gong, & Irwin, Jr., 1985)

ANOREXIA INCREASING; DEATH RATE HIGH

- The incidence of anorexia nervosa has nearly doubled over the past two decades, increasing from 0.35 per 100,000 between 1960 and 1965 to 0.64 per 100,000 between 1970 and 1976. (Herzog & Copeland, in HPPC-ACP, 1986)
- The rise in anorexia between 1970-1976 was seen most dramatically in adolescent and young-adult females from the upper social classes; rates of illness in males declined slightly during this period, while the rate in

middle-class females remained constant. (Strober, in Brownell and Foreyt, eds., 1986)

- Follow-up studies indicate mortality rates for anorexia nervosa patients of between 15-21%. In 1983, 101 deaths from anorexia were reported. (Diagnostic and Statistical Manual of Mental Disorders, 3rd edition [DSM-III]; FDA Consumer, May 1986)

IDEAL OF THINNESS TAUGHT EARLY; DIETING, INAPPROPRIATE WEIGHT CONTROL MEASURES COMMON

- When preschoolers ages 2-5 were presented with 2 life-size dolls, identical in all respects except corpulence, 91% of the children who expressed a preference indicated that they preferred the thin doll over the heavy doll. In the same study, fat girls and thin boys were seen as antisocial; thin children were seen as more competent than fat children; and thinner children tended to be liked more than children of average weight or heavier. (Dyrenforth, Wooley, and Wooley, in Kaplan, 1980)

- A survey of 494 San Francisco female children and adolescents, mostly from middle income families, found that while only 15% were actually overweight, more than 50% (31% of the 9-year-olds) thought they were too fat. Almost 1/2 of the 9-year-olds and 80% of the 10-year-olds were dieters. (Mellin, 1987)

- 59% of teenage girls would like to lose weight, while 33% are satisfied with their weight and 8% would like to gain. In contrast, 52% of boys would like their weight to stay the same, 28% would like to gain, and 20% would like to lose weight. Sixty-five percent of the girls say they would be more pleased with their appearance if they were thinner; only 39% of boys feel the same way. (Gallup, November 1985)

- More than 40% of teenage boys and 34% of teenage girls report having gone on food binges; more than 1/2 of these teenagers pursue extreme measures such as vigorous exercise, fasting, vomiting, or using purgatives, to compensate for food binges. (Gallup, November 1985)

- Of 907 college freshmen and seniors, 50% of the women and 13% of the men said they were "overweight" even though only 10% of the women and 11% of the men actually were overweight. Nearly 1/4 of the women and almost 10% of the men reported using one or more inappropriate methods of weight control, including fasting, diuretics, laxatives or self-induced vomiting. (Zuckerman, et al, 1986).

EATING DISORDERS POSSIBLY LINKED TO DEPRESSION, SUBSTANCE ABUSE, TROUBLED FAMILIES

While no single causal theory has been confirmed, the contributions of personality, family, culture and biology to the development of eating disorders continue to be explored. Among the findings are:

- Mood disorders, such as depression, and eating disorders are thought to be related but the nature of the relationship is unclear. Some maintain that the mood disturbance is secondary to the eating disorder; others claim that eating disorders may be variant expressions of an underlying depression; while others suggest that eating disorders are a product of the interplay of biological, psychological, familial and sociocultural forces. (Swift, Andrews, & Barklage, 1986)

- Immediate family and close relatives of anorexic patients were substantially more likely to have mood disorders than would be expected in the general popluation. (Strober, in Brownell & Foreyt, eds., 1986)

- One study found that eating disorders occurred in 6.4% of immediate relatives of anorexia nervosa patients, as compared to 1.3% of control relatives; another study reported a history of probable anorexia nervosa in immediate relatives in 29% of 102 consecutive cases. (Strober, in Brownell & Foreyt, eds., 1986)

- Of 275 bulimics attending an eating disorders clinic, 34% reported a history of alcohol and drug problems (Mitchell, Hatsukami, Eckert & Pyle, 1985 as cited in Killen, et al, 1987)

- A study of nearly 200 women found that bulimics perceived their families as being significantly less supportive and helpful than did normal controls and that their families did not encourage assertive, self-sufficient behavior. Despite a perception of tremendous familial conflict and anger, bulimics reported that open, direct expression of feelings was discouraged. (Johnson & Flach, 1985)

- In a study of parent-child relationships in 80 young women (bulimic, bulimic-anorexic, anorexic and normal controls), both bulimics and anorexics viewed their parents as more blaming, rejecting and neglectful toward them than did controls and they treated themselves with the same hostility and deprivation. Bulimics, but not anorexics, reported severe deficits in parental nurturance and empathy, relative to controls. (Humphrey, 1986)

LIMITED FEDERAL SUPPORT FOR EATING DISORDERS

- In FY 1986, NIMH funded 31 research grants related to eating disorders and appetite regulation (anorexia, bulimia, and obesity) totaling approximately $3 million. (NIMH, July 1987)

July 31, 1987

SUMMARY OF FULL COMMITTEE HEARING ON "WOMEN, VIOLENCE, AND THE LAW" WASHINGTON, DC, SEPTEMBER 16, 1987

On September 16, 1987, the Select Committee on Children, Youth, and Families held a hearing entitled, "Women, Violence, and the Law." The hearing examined how the American legal system--its laws, enforcement procedures, and attitudes--responds to women who are victims of domestic violence and marital and acquaintance rape.

Rana Lee, from Novato, CA, told the committee about her experiences as a battered wife. In her first marriage of 18 years, Lee suffered emotional and physical abuse. In her second marriage, Lee was repeatedly physically and sexually abused, beginning with her wedding night. In addition, her daughter was raped by Lee's husband at age 14. Lee testified that she did not press charges during her marriage because of fear and because she did not know there were shelters for abused women and their children. She added that marital rape was not a crime in California at that time.

Currently, Lee serves as a Community Education Developer with Marin Abused Women's Services. She explained that women will report marital rape and domestic violence to shelters but still fear that their husbands will kill them if they go to the police. According to Lee, young women are as likely to be involved in abusive relationships as are adult women. Lee conducted a survey of 3,000 Marin County high school students, and preliminary results indicate that 36% of the females reported physical or sexual abuse and 24% cited their boyfriends as their primary abusers.

Sheila Martin, from Washington, DC, testified that during her courtship and marriage, her husband repeatedly raped her, hit her, and choked her into unconsciousness. Her 12 year-old son often witnessed the abuse. According to Martin, the police refused to arrest her husband when she called for help. When she tried to file criminal complaints, her husband failed to appear in court and the police did not attempt to find him. Martin never tried to prosecute her husband for rape because District of Columbia laws do not expressly prohibit marital rape.

Martin explained that family violence had a serious affect on her son, who began acting out in school and getting into trouble with the police. Although she has left her husband, Martin reported that she is still not free from abuse. Martin's apartment has been burglarized by her husband repeatedly. In Martin's view, her only hope is that her husband may soon be committed to a mental health institution, not because he is a threat to her but because he poses a danger to the broader community.

The Hon. Elizabeth Holtzman, District Attorney, Kings County, NY, testified that violence against women exists in epidemic proportions in America. In her view, the legal system's response to marital rape is one of the most extreme manifestations of prejudical attitudes toward women. Marital rape is legal under various circumstances in 36 states. Holtzman noted that several states have recently abolished or limited marital rape exemptions, but in many states the parties have to be legally separated for the woman to charge rape. Some states have extended the marital rape exemption to encompass couples living together as well as "voluntary social companions."

Holtzman also testified that 50% of known cases of wife battering also involve child abuse, and that such abuse perpetuates itself from generation to generation. Studies have found that about 75% of male abusers were themselves abused as children, and that a majority of boys who witness violence at home grow up to abuse their mates. According to Holtzman, the criminal justice system has too often failed to respond adequately to domestic violence, in part because of deeply engrained social attitudes that legitimize battering. Holtzman urged Congress to take a lead role in changing laws that fail to respond to violence against women.

Alan Sears, former Executive Director, Attorney General's Commission on Pornography, and Legal Counsel, Citizens for Decency through Law, Scottsdale, AZ, stated Commission findings that pornography, especially violent pornography, results in physical, psychological, and social harm to women. Sears testified that while pornography is not a leading cause of violence against women, it is a significant factor. According to Sears, the Commission found that pornography has become more "hard core" over the last 17 years, with more violence, humiliation and degradation. Sears said conversations he has had with police officers suggest that sexual assaults have also become more violent. In some cases of marital rape, he reported, husbands force their wives to act out scenes from pornography. In addition, Sears testified that some studies have suggested that hard core pornography may increase the acceptance of rape myths and the social degradation of women.

Barbara Hart, Staff Counsel, Pennsylvania Coalition Against Domestic Violence, and Co-Director, National Clearinghouse on Battered Women's Self-Defense, Reading, PA, testified that the spectrum of civil and criminal remedies for battered women is too narrow. Restraining order statutes sometimes do not allow for an eviction of the abuser or for temporary child-custody orders, which would prevent a battered woman from having to abandon her children when separating from an abusive husband. Moreover, most restraining and protection order statutes only afford relief to victims of serious bodily injury, thus ignoring the victimization of women whose husbands hold them prisoner in their homes, subject them to sexual coercion, or destroy their property. Hart blamed the deficits in statutory language on attitudes and values that blame women for the violence inflicted upon them.

Hart said that implementation and enforcement of civil protection orders have been limited. Battered women who are white and middle class are more likely to receive relief than are black and lower-income victims. Further, victims of domestic violence receive less protection under the law than victims of stranger violence. An arrested batterer is more likely to be allowed to go home than a suspect arrested in a stranger crime. And in half the states, crime-victim compensation laws deny compensation to victims of family violence.

Charles Patrick Ewing, Ph.D., J.D., Associate Professor of Law and Psychology, State University of New York at Buffalo, Buffalo, NY, testified that most battered women who kill their batterers are held to an unreasonable standard of accountability when they try to defend themselves. He argued for expanding self-defense laws to include "psychological self-defense," which would justify the use of deadly force where such force appeared necessary to prevent the infliction of extremely serious psychological injury. Ewing said that a frequent question in the courtroom is why battered women who have killed did not flee their husbands and he gave several answers, including "learned helplessness", financial dependence, fear of harm, and an unresponsive criminal justice system that fails to protect these women if they do leave. Ewing argued that psychological self-defense has a precedent in common law that allows deadly force to prevent unlawful entry into one's home.

Lenore E. Walker, Ed.D., Executive Director, Domestic Violence Institute, Denver, CO, testified that battered women are doubly victimized in child custody disputes. She said that the majority of men who batter their wives also abuse their children. Her clinical experience indicates that children who witness domestic violence suffer negative psychological consequences. Yet judges rarely consider evidence of spouse abuse in determining parental fitness. Walker advocated a number of legal reforms including changing child-custody laws to exclude visitation rights and custody for batterers unless they can demonstrate that they no longer pose a threat to the women or children. Walker urged the expansion of self-defense laws to include justification for deadly force for battered people who demonstrate that a long history of abuse caused them to perceive reasonably that serious bodily harm or death was imminent. In Walker's view, the social attitudes that tolerate wife abuse are represented in the criminal justice system and inhibit progress in the response to battered women.

Former Det./Lt. Darrell H. Pope, Michigan State Police Commanding Officer, Sex Crime Unit, Lansing, MI, testified that passing laws to curtail pornography will reduce crimes of sexual assault. While commanding officer of the Sex Crime Unit, Pope studied 38,000 case files of sex-crimes committed in Michigan, and found that 41% of all sex offenders used pornography just prior to or during the crime. Pope advocated increased training for police, prosecutors and judges about rape and the trauma experienced by victims of rape, and expanded services for sexual assault victims.

WOMEN, VIOLENCE, AND THE LAW

A FACT SHEET

VIOLENCE AGAINST WOMEN COMMON IN U.S.: MAJORITY COMMITTED BY RELATIVES, ACQUAINTANCES

- In 1984, 2.3 million violent crimes (rape, assault, and robbery) were committed against women over age 12, compared with 3.6 million against males. (Bureau of Justice Statistics [BJS], Department of Justice, 1986)
- In 1986, 57% of violent crimes committed against women were committed by non-strangers, compared with 37% of violent crimes committed against men. (BJS, 1987)
- 77% of the victims of violent crimes committed by relatives are women. 70% of victims of violent crimes committed by strangers are men. (BJS, 1987)
- Crimes committed by relatives are more likely to involve attacks and injury and are more likely to require medical attention than crimes committed by strangers. (BJS, 1987)

DOMESTIC VIOLENCE ALSO COMMON; OFTEN INVOLVES RAPE

- Between 1978 and 1982, 2.1 million women were victims of domestic violence at least once during an average 12-month period. 1/3 of domestic violence between 1978 and 1982 involved rape, robbery or assault. During the 6-month period following an incident of domestic violence, 32% of the women were victimized again. (BJS, 1986)
- In 1986, 30% of female homicide victims were killed by husbands or boyfriends. (Uniform Crime Reports, Federal Bureau of Investigation [FBI], 1987)
- Battering and other physical violence were involved in 45% of the marital rapes reported in a representative sample of married women in Boston with children aged 6 to 14. (Finkelhor and Yllo, License to Rape: Sexual Abuse of Wives, 1985)
- Of the women in a San Francisco study who were currently or formerly married, 21% reported that they were subjected to physical violence by a husband. (Russell, Rape in Marriage, 1982)
- In a survey of women in the Rocky Mountain area who reported having been battered, 59% said they were forced to have sex with the batterer. (Walker, The Battered Woman Syndrome, 1984)

RAPE IS FASTEST GROWING VIOLENT CRIME; MAJORITY COMMITTED BY ACQUAINTANCES

- In 1986, a woman was a victim of rape or attempted rape every 3-1/2 minutes, totaling more than 153,000 rape victims. 51.3% of completed rapes in 1984 were committed by nonstrangers. (BJS, 1986, 1987)

- * Between 1977 and 1986, the number of rapes reported to the police increased 43%, making rape the fastest growing violent crime in the country. (FBI, 1978 & 1987)
- * Nearly 45% of women in a San Francisco random sample reported that they were subjected to at least one rape or attempted rape in their lifetime. 82% of the rapes were committed by nonstrangers and 2/3 of the victims were assaulted by acquaintances or friends. (Russell, 1982; Sexual Exploitation, 1984)
- * Ten to 14% of the married or formerly married women were raped or sexually assaulted by their current or former husbands; 3% reported that they were raped or sexually assaulted by strangers. (Russell, 1982; Finkelhor and Yllo, 1985)
- * Young women ages 16-19 have the highest rape victimization rates; 20-24 year olds have the second highest rates. 8% of white women and 11% of black women are likely to be raped in their lifetimes. (Koss & Harvey, The Rape Victim, 1987; BJS, 1987)
- * One in 8 women students reported experiences within the previous 12 months that met legal definitions of rape, according to an extensive 3 year survey. 84% of college students who were victims of completed rapes knew their assailant and two thirds of them were assaulted by a date. (Koss, Journal of Consulting and Clinical Psychology, March, 1987)

DOMESTIC VIOLENCE TAKES SERIOUS TOLL ON CHILDREN

- * A study of children in shelters for battered women found higher rates of child abuse in families where there is wife abuse than in other families. In 70% of the cases, the child abuse is committed by men. (Layzer et al, Center for Women Policy Studies, 1986)
- * A Colorado study found that 53% of battering husbands abused their children. (Walker, 1984)
- * In a majority of states, judges are not required to consider proof of domestic violence in determining child custody. Ten states and the District of Columbia require spousal abuse to be considered in temporary and/or permanent custody decisions (Alaska, Arizona, California, Colorado, Florida, Illinois, Iowa, Kentucky, Texas, and Washington). (National Center on Women and Family Law [NCWFL], 1987)
- * Men and women who saw their parents physically attack each other were 3 times more likely to hit their own spouses than were those with non-violent parents. The sons of the most violent parents have a rate of wife-beating 10 times greater than that of the sons of non-violent parents. (Straus, Gelles & Steinmetz, Behind Closed Doors, 1980)

LAWS INADEQUATE TO PROTECT WOMEN AGAINST RAPE AND DOMESTIC VIOLENCE

- State laws vary regarding treatment of marital rape. In nearly 3/4 (36) of the states, under many circumstances it is legal for a husband to rape his wife. (NCWFL, 1987)

- In 7 states, exemptions from prosecution for rape extend to cohabitants (Connecticut, Delaware, Iowa, Kentucky, Minnesota, Montana, and West Virginia). In 5 states, a partial exemption extends to voluntary social companions with whom the victim has previously had sexual contact (Delaware, Hawaii, Maine, Montana, and Pennsylvania). (NCWFL, 1987)

- 5 states and the District of Columbia require mandatory arrest for domestic violence when police have probable cause to believe that a misdemeanor has been committed (Connecticut, Louisiana, Nevada, Oregon, and Washington). One state requires mandatory arrest when police have probable cause to believe that a felony has been committed (Maine). (NCWFL, 1987)

- 8 states require mandatory arrest for restraining-order violations (Delaware, Maine, Minnesota, Nevada, North Carolina, Oregon, Washington State, and Wisconsin). (NCWFL, 1987)

VICTIMS OF ASSAULT BY ACQUAINTANCES UNLIKELY TO REPORT THE CRIME

- Only 5% of women college students who reported forced sex during the previous year reported the incident to the police. (Koss, 1987)

- Less than 10% of rapes reported in the San Francisco survey had been reported to the police. (Russell, 1984)

- A minority of rape victims who contacted rape crisis centers in Massachusetts reported their victimization to the police. (Waldron & Dodson-Cole, Massachusetts Department of Public Health, 1986)

POLICE, COURTS FAIL TO REDRESS VIOLENCE AGAINST WOMEN BY HUSBANDS AND ACQUAINTANCES

- Studies aross the nation have found that rapes by acquaintances are 2 to 5 times less likely to result in an indictment than rapes by strangers. (Estrich, Real Rape, 1987)

- In only 1.7% of domestic dispute calls to police in St. Petersburg is an arrest made. (St. Petersburg Times, 5/21/84)

- 70% of police officers interviewed said they completed written reports in fewer than 20% of domestic violence cases; 13% of the officers said they never reported family disturbances. (Lerman, Harvard Journal on Legislation, 1984)

- A Minnesota study found that arrest is more effective in preventing further violence in cases of domestic dispute than either police mediation or separation of the parties for the night. (Sherman & Berk, American Sociological Review, 1984)

Revised - October, 1987

SUMMARY OF FULL COMMITTEE FIELD HEARINGS ON "THE CONTINUING INFANT MORTALITY CRISIS IN ILLINOIS" SPRINGFIELD AND CHICAGO, IL, OCTOBER 5, 1987

The Select Committee on Children, Youth, and Families held two field hearings in Springfield and Chicago, Illinois, to explore barriers to comprehensive prenatal care for low income and other women at risk of having a low birthweight infant. Low birthweight is a major predictor of infant mortality and childhood disability.

In Springfield, the Committee visited the High Risk Neonatal Center at St. John's Hospital, which is composed of six nurseries offering different levels of critical care. The average length of stay is 20 days at an average cost of $20,000. Fifty-five percent of the infants are Medicaid eligible and 10% have no source of payment.

At the hearing, the Committee first heard from two mothers who did not receive early prenatal care because they had difficulty finding a physician. Myriam Velazquez, age 20, Springfield, was evicted from her parents' Chicago home when she was six months pregnant, and moved to Springfield to live with a friend. After calling at least ten doctors, the only medical practice that would accept her as a Medicaid client had a 65-person waiting list. Although she was 7 months pregnant, they made no exception for her. She was persistent and found a doctor who also referred her to WIC. Velasquez developed gestational diabetes and anemia that might have been prevented with earlier prenatal care and WIC services.

Lynn Rynders, also from Springfield, was married at the time of her pregnancy, but had no health insurance. Because her husband was employed, she was not Medicaid eligible without first spending a monthly amount on medical care ("spend-down" policy under the optional Medicaid Medically Needy Program). Several physicians would not accept her unless she could pay up front for the initial visit. Unable to come up with the fee, or the Medicaid spend-down, she went without prenatal care until a severe asthma attack sent her to a hospital emergency room. Concerned about her health, she continued to pursue alternatives. During the second trimester of pregnancy, she found a program that referred her to a medical resident and paid the fee. Her baby had medical complications at birth.

Bernard Turnock, MD, Director, Illinois Department of Public Health, described state efforts to reduce Illinois' high infant mortality rate (12.0 infant deaths per 1000 live births) including the state's newest initiative, "Families with a Future," (Infant Mortality Reduction Initiative [IMRI]) and the innovative "Parents Too Soon Program." Illinois also has expanded WIC with state general revenue funds to serve an additional 12,000 cases. Citing the association between low birthweight and infant mortality, Turnock emphasized the state's efforts to expand access to prenatal care. In Illinois, infant mortality rates for births to women receiving inadequate or no prenatal care were more than four times that for babies of women receiving adequate care. The proportion of low birthweight infants born to mothers who received no prenatal care was more than three times that of infants whose mothers began care in the first trimester.

Sister Ann Pitsenberger, Executive Vice President, St. John's Hospital, Springfield, identified precursors to infant mortality in Illinois' south central region, including high malpractice premiums; increasing unemployment with loss of health benefits; inadequate and untimely reimbursement from the state, discouraging providers from serving Medicaid clients; transportation problems; inadequate follow-up; and lack of case management. Pitsenberger stressed that despite the contribution of neonatal intensive care to reducing infant mortality, its further development is fiscally impractical. Local efforts to enhance prenatal care access have been hindered by cuts in Medicaid and the MCH block grant. Pitsenberger announced the development of a prenatal care program at St. John's for low income women not eligible for Medicaid and for Medicaid recipients.

Cynthia Fraed, MD, Harrisburg, IL, told the Committee that the obstetrician shortage, especially in the 7 southern counties of Illinois, was causing a "desperate" situation. Increasing medical malpractice insurance premiums, and insufficient Medicaid reimbursement from the state for prenatal and delivery services, especially when there are medical complications, contributed to her personal decision to stop serving public aid clients.

Edward Fescoe, MD, President, Illinois State Medical Society, Chicago, and James Singleton, MD, Springfield, reiterated Dr. Fread's explanation of declining access to early prenatal care for low-income and Medicaid eligible women. Dr. Fescoe also raised concerns about teen pregnancy and its contribution to high infant mortality rates, particularly in rural southern Illinois where there is an acute shortage of obstetricians, and a very high teen pregnancy rate.

Joan Reardon, a counselor at the Care Center of Springfield, a non-profit agency offering crisis intervention for pregnant teens and low-income women, described the struggle many of their clients face in obtaining medical care, including difficulties in documenting Medicaid eligibility; an unrealistic Medicaid spend-down for working families; and difficulty in finding a physician who will accept Medicaid once the client is deemed eligible. Reardon stressed that a few physicians provide a disproportionate share of indigent care. They are poorly compensated and high medical malpractice rates are making it difficult for them to continue. Physicians are willing to see indigent clients referred through the Care Center because they are reimbursed at the Medicaid rate, and the Care Center provides emotional support and nutritional services to the women.

Sandra Landis, Executive Director, Planned Parenthood Springfield Area, stressed the importance of basic preventive health services, including family planning, to the reduction of infant mortality. When seeking early prenatal care, their clients have encountered limited physician availability, waits of 8 to 12 weeks, and prohibitive fees.

Sharon Eisenstein, Director of Social Services, Southern Seven Health Department; and Project Director, Parents Too Soon Demonstration Project, Ullin, described the limited medical and social services available in a large rural area where high unemployment, poverty, inadequate housing, and limited transportation are prevalent. In the 2,000 square mile area served by the Southern Seven Health Department, no hospital provides delivery services. In the entire 7 county area, only 2 physicians at two federally funded health centers will accept Medicaid clients. All of these factors contribute to above average rates of teen pregnancy, low birthweight and infant mortality.

To address these problems, the health department, through programs such as Parents Too Soon, provides transportation, case management, parenting education, financial assistance for prenatal care, and counseling and referral. The Ounce of Prevention Home Visiting Program provides additional services until the infant reaches 18 months. Among the 424 infants delivered to teens through the program, the infant mortality rate is 0% compared to 17.3% in the 7 county area. Low birthweight was reduced to 6%, well below the national rate for infants born to teen mothers. One reason for their success is physicians' willingness to participate because reimbursements are possible within 30 days, and comprehensive support services, including transportation, are provided by the program.

Barbara Burke Dunn, Director, Community Health Improvement Center, Decatur, described the preventive health care services offered by a federally funded health center in Macon County to low income infants, children, and adults, 70% of whom are Illinois Public Aid recipients. The infant mortality rate in Macon County was 13.6/1,000 in 1986, and 6.7% of the women who delivered infants in 1986 had late or no prenatal care, compared with a state rate of 4.6%. Dunn said that the loss of manufacturing jobs in Decatur left many families unemployed or dependent on lower paying jobs that offer no health benefits, and Medicaid eligibility is too restrictive to cover these working families. Dunn also addressed the physician shortage in rural and disadvantaged areas of the state, and stressed that without the National Health Service Corps, community health centers, such as hers, would not be able to function.

In Chicago, Emma Scott, a 32-year old married mother, without health insurance and at high risk for having a premature baby, testified that she waited one month for the free specialized prenatal care she needed at the only clinic that would see her, traveled long distances to get there, and waited long hours to see a resident. Her baby weighed only 3.5 pounds at birth.

Lonnie C. Edwards, MD, Commissioner, Chicago Department of Health, discussed the disparity between black and white infant death rates in Chicago, especially during the postneonatal period. In addition to socioeconomic conditions and lifestyle factors, Edward identifed access to comprehensive prenatal care services as a critical factor in reducing infant mortality. Yet 23% of Chicago women received inadequate prenatal care in 1984; as many as 20% of Chicago residents have no health insurance, and Medicaid covers only the most impoverished. The Commissioner described Chicago's implementation of IMRI through community networks of local agencies and organizations, and the partnership in Health Program, a cooperative arrangement between the city health department and community hospitals to prepay hospitals for assured delivery services.

Edward T. Duffy, Director, Illinois Department of Public Aid, identified the high cost of medical malpractice insurance as a major inhibitor of prenatal care access. According to Duffy, raising physician reimbursement alone will not increase the supply of physicians willing to accept Medicaid clients. He also discussed the Department's "Healthy Kids Program" (Illinois' Early and Periodic Screening, Diagnosis, and Treatment Program under Medicaid), which screened 201,271 of the 630,000 eligible children in 1986. Duffy testified that the Department plans to extend Medicaid to pregnant women who fall within the current income standard and the federal poverty level, but due to limited resources, the expansion is unlikely to occur this year, even though it is permissible under federal law to cover pregnant women and infants in families earning up to 100% of the federal poverty level.

Jerry-Stermer, President, Voices for Illinois Children, Chicago, stressed that Illinois' high infant mortality rate is an unnecessary tragedy given that Congress provided states the option to expand Medicaid eligibility to low-income pregnant women with the federal government paying half the cost. More than 11,000 uninsured low-income women in Illinois do not receive early prenatal care. Illinois passed legislation to require the Department of Public Aid to design a plan to implement the federal law, but without deadlines or guarantees of how many mothers will be insured. Stermer testifed that the up-front cost to Illinois of insuring these women would be $2 million per year, with a net saving of $3 for every $1 spent.

Jennifer Artis, President, Healthy Mothers and Babies Coalition, and Executive Director, St. Basil's Free People's Clinic, testified that the quality of available health care can be a determining factor in how readily care is utilized. However, Artis added, the primary barrier to care is financial. St. Basil's Clinic has provided primary medical care to 8,000 new patients at no charge since 1982. Artis made recommendations to improve the city's infant mortality rate, including improved funding and efficiency of the WIC program; expansion of home health care services and public health nurses; evaluation of the State's IMRI project; development of in-school nutrition, health and child care programs for teens; Medicaid eligibility expansion; and more effective monitoring of HMO facilities.

Gertrude Washington, Project Director, Austin Infant Mortality Network, Chicago, and Convenor of the Council on IMRI, described the efforts of 10 IMRI projects serving 19 communities. The community-based networks provide case-finding and case management services focused on low birthweight prevention. In 1985, 10.1% of all babies born to Chicago residents were low birthweight and accounted for almost 70% of all infant deaths. In 1985, the risk of low birthweight among blacks was more than two times greater than among whites. In 1986, the infant mortality rate in the 19 targeted communities was 22 deaths per 1,000 live births, 33% higher than the infant mortality rate for all Chicago's residents.

Maria Brown, DO, Chicago, a family physician at Cook County Hospital, described her personal experiences in working with urban poor clients, many of whom are young and do not receive early prenatal care. She described the difficulties many women have when they have no medical insurance, when they don't qualify for medical care, and must travel long distances by public transportation to Cook County Hospital which provides the high risk prenatal and delivery services they may require.

William Weigle, MD, a retired physican from Aurora, IL, testified that low-income women with no source of health care coverage or payment are receiving inadequate or no prenatal care. He also testifed that medical malpractice premiums and low Medicaid reimbursement rates are largely responsible for the increasing numbers of underserved pregnant women. Weigle reported that the Kane County Health Department, using state and County funds, will set up a private prenatal care program for the underserved in which physicians will be reimbursed for the cost of their malpractice premium.

Useni Eugene Perkins, Social Services Director, Chicago Urban League, described their role in administering one of 10 IMRI networks. The five communities they serve have the highest infant mortality rates in the city. Perkins stressed that a real reduction in the City's infant mortality rate must focus on socio-economic conditions such as high rates of unemployment, poor sanitary conditions, and inadequate housing. Perkins recommended better coordination and cooperation among federal, state and local agencies; greater involvement of perinatal centers in community networks; an increase in home visiting nursing staff; more affordable and higher quality housing; expansion of WIC; a more comprehensive school health education program; a case management system to identify and track every high risk mother and infant for a minimum of 3 years; a federal budget that prioritizes the health, economic and social needs of a high risk population that is disproportionately black and other minorities; and the enactment of HR 1398, the "Quality of Life Action Act," to ensure full employment.

Carmen Velasquez, Board member of Project Alivio, Chicago addressed health issues affecting Hispanic families in Chicago. Given the high fertility rate in the Hispanic community, Velasquez called for more attention to morbidity and mortality prevention in this group. The Hispanic population is young, growing rapidly, working but underinsured or uninsured, and ineligible for many government funded programs. The rate of medical indigency in the Hispanic community in Chicago is estimated to be 30%-40%. The majority of indigent Hispanic clients using public health care facilities are not citizens or permanent residents and do not qualify for public assistance. Even two-parent Hispanic working families rarely have adequate insurance to cover their families. Infant mortality rates and other data to describe the health status of Hispanic infants and children in Chicago are lacking because the State does not include Hispanic as a classification on either birth or death certificates. Valesquez recommended revised eligibility criteria for the state's IMRI project, WIC and public aid that reflect the needs of the Hispanic community. She also announced the establishment of Project Alivio, developed by members of the Hispanic community, to improve the delivery and evaluation of health care services; to offer education, training and employment services to address the shortage of Hispanic health care professionals; and to provide child care.

THE CONTINUING INFANT MORTALITY CRISIS IN ILLINOIS

A FACT SHEET

INFANT MORTALITY RATE CRITICALLY HIGH; ILLINOIS AMONG NATION'S HIGHEST

- The U.S. ranked last (tied with Belgium, the German Democratic Republic and the German Federalist Republic) among 20 industrialized nations in its infant mortality rate (IMR)[1] in 1980-85. (Children's Defense Fund [CDF], 1987)

- In 1985, there were 40,030 deaths of infants under 1 year nationwide, an IMR of 10.6. For white infants, the rate was 9.3, essentially the same as in 1984; for black infants, the rate was 18.2, compared with 18.4 in 1984. (National Center for Health Statistics [NCHS], 8/87)

- Neonatal mortality rates (NMR)[2] for all infants were essentially the same in 1984 and 1985 (7.0); postneonatal mortality rates (PNMR)[3] for white infants were about the same in 1985 (3.2) as in 1984 (3.3), continuing a 3-year pattern. For black infants, the PNMR declined between 1984 (6.5) and 1985 (6.1), continuing the decline observed from 1983 (6.8) to 1984. The downward trends in the NMR and PNMR have slowed recently for infants of both races. (NCHS, 8/87)

- With the exception of Illinois, the 10 States with the highest overall IMR's in 1984 were all southern (DC, SC, MS, AL, GA, NC, VA, LA, and TN). (CDF, 1987)

- In 1986, Illinois had an IMR of 12.0, up from 11.6 the previous year. In 1984, the IMR for blacks (20.4) in Illinois was more than twice as high as that for whites (9.4). (Illinois Department of Public Health [IDPH], 1987)

LOW BIRTHWEIGHT RATE PLATEAUS; REMAINS STRONG PREDICTOR OF INFANT MORTALITY

- Low birthweight (LBW)[4] infants in the U.S. are nearly 40 times more likely to die in the 1st month of life and are 3 times more likely to have neurodevelopmental handicaps and congenital anomalies than normal infants. (Institute of Medicine [IOM], 1985)

- In 1985, 67% of infant deaths during the 1st month and 50% of deaths in the 1st year of life were attributable to LBW. (Government Accounting Office [GAO], 9/87)

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[1] Infant mortality rate (IMR)= deaths to infants under 1 year/1,000 live births.

[2] Neonatal mortality rate (NMR)= deaths to infants under 28 days/1,000 live births.

[3] Postneonatal mortality rate (PNMR)= deaths to infants 28 days-11 months/1,000 live births.

[4] Low birthweight (LBW)= 5-1/2 lbs. (2,500 grams) or less at birth.

- In 1985, 6.8% of all live births (about 254,000 babies) were LBW, the same rate as in 1980. In Illinois, the proportion of LBW infants rose from 7.2% in 1982 to 7.5% in 1986. (GAO, 9/87; IDPH, 1987)

- The proportions of very LBW[5] infants were higher in 1984 than in 1978 for both white and black infants. (NCHS, 12/86)

- Of the babies born to Medicaid recipients and uninsured women recently surveyed by GAO, 12.4% were LBW. (GAO, 9/87)

- Babies born to women who receive no prenatal care are 3 times more likely to be of LBW than those born to mothers who receive early care. (GAO, 9/87)

INFANT MORTALITY, LOW BIRTHWEIGHT MORE LIKELY AMONG BABIES OF TEENAGE MOTHERS

- Infants born to teenage mothers are 60% more likely to die in the neonatal period and about twice as likely to die in the postneonatal period as those born to mothers over age 20. These infants are 2-3 times as likely to be LBW as infants born to mothers in their 20's or 30's. (Congressional Research Service, 1/86)

- In 1984, 13% of all births were to teenagers. 13.6% of mothers under 15, 10.3% of mothers ages 15-17 and 8.8% of mothers ages 18-19 had LBW infants. (NCHS, 7/86; Select Committee on Children, Youth, and Families [CYF], 3/87)

- In 1985, 12.5% of births in Illinois were to teenage mothers, 10.7% of whom had late prenatal care and 10.3% of whom had LBW infants. (IDPH, IL County Area Rates and Rankings, 1985)

- While the average annual IMR among all Illinois women between 1982-84 was 10.0, it was 21.5 among 15-17 year olds and 17.4 among 18-19 year olds. (CYF, 12/85)

SMOKING AND ALCOHOL ABUSE PLACE INFANTS AT RISK OF DEATH, LOW BIRTHWEIGHT

- In the U.S., maternal smoking results in roughly 50,000 fetal deaths and 4,000 infant deaths each year; about 36,000 (15%) LBW babies born in 1983 were underweight because their mothers smoked during pregnancy. (CYF, 5/86)

- Between 3,700 and 7,400 babies were born with fetal alcohol syndrome (FAS) in 1982; 80% of children with FAS have pre- and postnatal growth retardation requiring neonatal intensive care. (CYF, 5/86)

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[5] Very low birthweight = under 3 lbs, 3 oz (1,500 grams) at birth.

PRENATAL CARE REMAINS UNAVAILABLE TO MANY

- From 1979-1985, the proportion of mothers who did not begin prenatal care in the critical first trimester of pregnancy remained stagnant at 24%. 21% of white mothers and 38% of black mothers in 1985 did not receive early prenatal care. (NCHS, 7/87)

- In Illinois, while there was a slight improvement in the proportion of women receiving prenatal care in the first trimester from 77% in 1982 to 78% in 1986, the percentage of women with very late or no care increased (4.3 % in 1982 compared with 4.7% in 1986). (IDPH, 1987)

- Approximately 11,400 low income women who receive late or no prenatal care deliver babies in Illinois each year. (Voices for Illinois Children, 8/87)

- Nearly 63% of Medicaid recipients and uninsured women (69% of low-income teens) and 29% of women with private health insurance surveyed by GAO, received insufficient prenatal care. 16% of Medicaid recipients and 24% of uninsured women surveyed (but only 2% of privately insured women) began prenatal care during the last 3 months of pregnancy or made 4 or fewer visits. (GAO, 9/87)

- In 1984, 17% of women of reproductive age lacked insurance to pay for prenatal care and another 9% had only Medicaid coverage. (GAO, 9/87)

- In 1986, the average Medicaid reimbursement rate for total maternity care was about $473 nationwide and $446 in Illinois, while the median physician charge for such care was more than twice as high ($1,000). (GAO, 9/87)

- A 1985 survey indicated that obstetricians/gynecologists (ob/gyn's) paid an average of $20,818 for insurance coverage in 1984. The mean cost of coverage in the Mid North region, which includes Illinois, was $23,025, or 11.1% of mean gross income. For those reporting increases, premiums had risen an average of $9,871 since 1983, and an average of $13,361 in the Mid North region. (American College of Obstetricians and Gynecologists [ACOG], 11/85)

- As of 1985, 12.3% of ob/gyn's nationwide had given up obstetrics due to liability pressures. 23.1% had decreased the level of high risk obstetrical care and 13.7% had decreased the number of deliveries they performed. (ACOG, 11/85)

- In 1984, an estimated 40% of high-risk pregnant women and children eligible for the Supplemental Food Program for Women, Infants and Children (WIC) were served; less than half (48%) of eligible Illinois women and children were served. (U.S. Department of Agriculture [USDA], 1987; CDF, 1987)

PRENATAL CARE, PROPER NUTRITION PROMOTE INFANT HEALTH, SAVE PUBLIC DOLLARS

- A woman who has 13-14 prenatal visits has only a 2% chance of having a LBW baby. Without any prenatal care, the risk is over 9%. (GAO, 9/87)

- WIC participation leads to longer pregnancies, leading to fewer premature births, and fewer fetal and neonatal deaths. For every $1 invested in WIC's prenatal component, as much as $3 are saved in short-term hospitalization costs. (USDA, 1/86; CYF, 8/85)

- Every $1 spent on prenatal care for high-risk women could save $3.38 in the cost of neonatal intensive care, on which more than $2.4 billion is spent annually. (IOM, 1985; GAO, 9/87)

10/5/87

SUMMARY OF COMMITTEE FIELD HEARING "PARENTS: THE MISSING LINK IN EDUCATION REFORM," INDIANAPOLIS, INDIANA, NOVEMBER 16, 1987

On November 16, 1987, the Select Committee on Children, Youth, and Families held a hearing in Indianapolis, Indiana, on parent involvement in education reform.

Diane Winters, Parent/Teacher, Weisser Park School, Fort Wayne, IN, testified that parent-school partnerships are the best way to help children reach their potential. Because most parents do not feel comfortable at their children's schools, she said, schools need to 1) give parents specific reasons for going there and 2) take steps to make them feel welcome. As a teacher, Winters has encouraged parent involvement through such activities as field trips; informal parent-teacher meetings; opportunities for parents to serve as tutors; and parent attendance at the first day of school to get acquainted with the school and with their children's teachers.

Elaine M. Amerson, Parent, Indianapolis, IN, testified that many principals, central office administrators, and state and federal authorities create and/or fail to remove barriers to meaningful parental involvement. She said these authorities see parents as threats rather than resources, and even when school committees include parents, their input often is not taken seriously because they are not "experts." She added that parents must accept some of the blame for failing to make time to participate or limiting their involvement to only those issues that are most controversial at the moment (e.g., sex education). She said that middle-schools in particular need increased parent involvement, because children are at a critical stage during those grades and because parents tend to distance themselves as their children reach puberty. She praised Indianapolis' middle school improvement project, which gives parents a role in designing reforms.

Joan Jeter Slay, Parent, and Training Coordinator, Designs for Change [DFC], Chicago, IL, testified about DFC's recruitment, training, and leadership development efforts, designed to involve low-income and minority Chicago parents in their children's local schools. She said that low-income parents perceive education as the only bridge to a better life for their children but most don't know how to supplement their child's education when their own skills are limited. She testified further that schools often actively alienate parents and interfere with parent involvement efforts. She said that the federal government needs to provide incentives (financial and other) so that school districts and states will include parents n the process of planning education reform. She said that DFC's work with parents had resulted in dramatically increased parent involvement, in parents going back to school, and in their taking leadership roles in their communities.

Yvonne Chan, Ed.D., Principal, Sylmar Elementary School, Sylmar, CA, Chan discussed barriers to parent participation, including: language and cultural differences; poor school/parent communication; parents' feelings of inferiority and reluctance to participate; poor understanding of the educational system; lack of time; and transportation and child care problems. Chan described programs to increase and improve parent involvement in Sylmar Elementary's ethnically diverse community. The programs, which bring parents into the school, provide parent education, and involve parents in the workings of the school, have resulted in increases in reading and math test scores; improved attendance; fewer students left at home without adult supervision; fewer referrals of Hispanic students to special education or to the principal for disciplinary reasons; and increased interest in higher education. Parents, she said, now express higher expectations for their children. 28% of the parents who did not speak English are now learning to do so.

Mildred Winter, Director, Parents as Teachers [PAT], University of Missouri, St. Louis, MO, described the PAT program, which teaches parents how to help their children learn during the first 3 years of life. Begun in 1981, PAT serves families of all backgrounds and is now offered in all Missouri school districts. Parents in PAT receive regular home visits by parent educators who teach them how to foster intellectual and social development, and how to discipline without punishing. Program evaluation has found that, regardless of socioeconomic disadvantages and other risk factors, enrolled children were more advanced than their peers in both language and social development and in problem solving. One district serving pregnant teens and adolescent parents reduced their dropout rate to zero. Winter said Missouri legislators have been willing to expand PAT because it is cost effective.

Henry Levin, Ph.D., Director, Center for Educational Research at Stanford, Stanford University, Stanford, CA, testified that immediate intervention is needed for the many educationally disadvantaged students in America. He said that increasing parent involvement is essential, but it must be implemented as a part of larger reforms. He described his own accelerated schools program for disadvantaged children, which fosters parent participation and is currently being tested at two elementary schools in California. Levin's program aims to bring educationally disadvantaged children up to grade level and focuses on raising parents' and educators' expectations. Parents are given literacy training and are taught about activities they can do at home to help their children learn. According to Levin, parents must be shown that they can visibly affect their own children's education so they are motivated to become involved.

Joan Lipsitz, Program Director, Elementary and Secondary Education, Lilly Endowment, Indianapolis, IN, testified that researchers and educators have overlooked the developmental problems and needs of early adolescence until recently. Because the number of students who fail or fall behind in school grows almost uncontrollably in middle-school, and because failure is a strong predictor of dropping out, Lipsitz argues that middle school is a critical period that must be targeted with special programs. Acknowledging that parent involvement requires substantial time, energy and money, she said that schools have to go to extraordinary lengths to enable a child with uninvolved parents to achieve as well as peers who have parental support. In such an equation, parent involvement is less costly than parent apathy.

Izona Warner, Parents In Touch [PIT], Indianapolis Public Schools, Indianapolis, IN, described the PIT program, an 8-year-old parent involvement program of the Indianapolis Public Schools which fosters parent communication with teachers and schools mainly through structured parent/teacher conferences. Parents are told what the school expects from their children and they sign "contracts" in which they agree to participate in their children's education. PIT also involves parents in school committees and task forces. Warner said that parent participation in PIT schools has increased at each grade level; student achievement scores have gone up; and PIT is due part of the credit. In some cases, parents themselves have gone back to school and improved their circumstances.

Mary Jackson Willis, Director, School Council Assistance Project, College of Education, University of South Carolina, testified that the missing link in education reform is that formal state or national policies do not give parent involvement proper recognition or funding. She said that in 1977, South Carolina mandated advisory councils in every school (K-12) to provide more local accountability in academic programs and planning. These councils helped achieve: increased parent involvement in setting program goals, and improvements in school/community relations, communications with local school boards, discipline, and principal selection. A 1984 state education reform law strengthed the councils to give them a role in directing school improvement. The state also funds a training and technical assistance project for School Improvement Councils statewide.

Ann Kamps, Administrative Assistant to the First Lady, Office of the Governor, Little Rock, AR, described the Home Instruction Program for Preschool Youngsters (HIPPY), a home-based, preschool education program offered in Arkansas to improve the educational achievements of at-risk children. Developed in Israel, HIPPY promotes awareness by parents that they are their children's primary teachers. Parents with limited reading skills are given education so that they can participate. Although evaluation of HIPPY in Arkansas has yet to be completed, program participants in Israel were 26% less likely to need remedial help in school.

Marcela Taylor, Senior Officer, Center for Community Relations and Special Populations, Indiana Department of Education, Indianapolis, IN, discussed parent participation efforts in Indiana. The State's efforts include statewide and regional conferences for parents; a 1986 state Department of Education committee, which studied ways to increase parent involvement and made recommendations for schools; and a 1987 state General Assembly Committee on Student Attitudes, Motivation, and Parental Involvement, which will award $1,000 grants for schools.

"PARENTS: THE MISSING LINK IN EDUCATION REFORM"

A FACT SHEET

PARENT INVOLVEMENT RAISES STUDENT ACHIEVEMENT AND ENHANCES DEVELOPMENT FOR EVERY AGE GROUP

Preschool

- Children under age 3, whose parents participated in Missouri's New Parents as Teachers Project (NPAT), "consistently scored significantly higher on all measures of intelligence, achievement, auditory comprehension, verbal ability, and language ability" than their peers, according to an independent evaluation. (Missouri Department of Elementary and Secondary Education, 1985)

- Head Start, the federally funded early childhood education program for low-income children and in which parent involvement is key, has been shown to improve students' academic achievement and to help participating parents improve their own educational and economic status. (Hubbell, et al, 1985; Zigler, et al, 1979)

Elementary and Secondary Schools

- A study of Maryland third and fifth graders indicated that students in classrooms of teachers who frequently use parent involvement in learning activities make greater reading gains than students in other teachers' classrooms. (Epstein, In press)

- Students in grades three through five in seven New Haven schools employing a broad-based parent involvement program, showed significantly greater improvement in behavior, attendance, and classroom reading grades than students in the control group. (Haynes and Comer, Unpublished paper, 1987)

- A long-term program to change the governance and organization of two of the lowest achieving inner-city New Haven, Connecticut, elementary schools, partly by including substantial parent involvement, resulted in bringing the students up to grade level. One school moved from 20th in reading and 31st in math to 10th place in both among all New Haven schools. And within the first five years of the program, both schools attained the best attendance records in the city. (Comer, 1984 and 1980)

- A study of sixth graders in Oakland, California, found that children whose parents spend time with them in educational activities or are involved in school activities, achieve more in school, regardless of socioeconomic status. (Benson, 1980)

- A study of 16- and 18-year-old students found that students whose mothers had attended at least one PTA meeting were 10% less likely to be enrolled below grade level. (U.S. Department of Education, 1986)

UNDERACHIEVEMENT OF U.S. STUDENTS UNDERSCORES NEED FOR PARENT INVOLVEMENT

* Less than 75% of all 18 and 19 year olds have finished high school. (U.S. Department of Education, 1986)

* 90% of the jobs created in New York City over the next 12 years will require a high school diploma, yet only 2/3 of the City's students graduate from high school. (Committee for Economic Development, 1987)

* In Chicago, only half the students who enter high school graduate. (Lefkowitz, 1987)

* Roughly 1/3 of all high school students are one year behind grade level. Another 5% are at least 2 years behind. Students held back a grade are up to 4 times more likely to drop out than those who are not. (Institute for Educational Leadership, March 1987; Census Bureau, 1986)

* U.S. children scored 6 percentage points below the mean for the 14 developed countries participating in the Second International Mathematics Study. (Livingstone, June 1985)

INCREASING NUMBERS, DIVERSITY AND IMPOVERISHMENT OF STUDENTS MEAN GREATER CHALLENGE TO ASSURE MEANINGFUL PARENT INVOLVEMENT

* An estimated 45.3 million students were enrolled in elementary and secondary education in the fall of 1986, declining 2% since from 1980 and more than 11% since 1970. By 1990, enrollment is again expected to surpass 1980 levels. (Select Committee on Children, Youth, and Families, 1987; U.S. Department of Education, 1987)

* Between 1970 and 1986, the percentage of children under age 18 living in single parent households increased from 11.8% to 23.5%. (Select Committee on Children, Youth and Families, 1987)

* By 1995, 2/3 of all pre-school children (14.6 million) will have mothers in the work force. Four out of 5 children between the ages of 7 and 18 are expected to have working mothers. (National Institute of Child Health and Human Development, 1986; Marx, 1987)

* Between 1970 and 1984, the latest year for which statistics are available, minority enrollment in public elementary and secondary schools increased from 21% to 30% of total enrollment. (U.S. Department of Education, 1986; U.S. Department of Health, Education, and Welfare, 1972)

* In 1985, 20% of all children lived in impoverished families, compared to 15% in 1970. This includes 43% of black children, more than 1/3 of Hispanic children, and less than 1/5 of white children. (Select Committee on Children, Youth, and Families, 1987)

* On average, each year a child lives in poverty increases the likelihood by 2 percentage points that he or she will fall behind grade level. Sixteen year olds who had spent 8 or more years in poverty during childhood were almost

twice as likely to be found enrolled below grade level than were children who had spent 2 or fewer years in poverty. (U.S. Department of Education, 1986)

* Between 1970 and 1986, the percentage of children living in single parent households increased from 11.8% to 23.5%. In 1986, only 64% of all children were living with both biological parents. (Select Committee on Children, Youth, and Families, 1987)

November 16, 1987

LIST OF WITNESSES AND THOSE WHO SUBMITTED TESTIMONY FOR THE RECORD

AIDS AND YOUNG CHILDREN: EMERGING ISSUES (2/20/87)

Badger, John D., National Director, Aid to Adoption of Special Kids, San Francisco, CA
*Barrick, William, R.N., M.S.N., Program Manager, AIDS Project, Alta Bates/Herrick Hospitals, Berkeley, CA
*Benjamin, Robert, M.D., M.P.H., Chief, Bureau of Communicable Diseases Alameda County Department of Community Health Services, Oakland, CA
*Grossman, Moses, M.D., Professor of Pediatrics and Vice Chairman, Department of Pediatrics, University of California at San Francisco; Chief of Pediatrics, San Francisco General Hospital; Chairman, San Francisco Health Department Task Force on Pediatric and Perinatal AIDS; Member, Mayor's Task Force on AIDS, San Francisco, CA
*McIntosh, Jean, M.S.W., Assistant Director, Los Angeles County Department of Children's Services, Los Angeles, CA
*Quackenbush, Marcia, M.S., Coordinator, Youth and AIDS Prevention Project, University of San Francisco AIDS Health Project, San Francisco, CA
*Smith, Carl, Vice President, Public Affairs, Alta Bates Corp., Berkeley, CA
*Swartzberg, John, M.D., F.A.C.P., Co-Medical Director, Alta Bates/Herrick Hospital AIDS Services, Berkeley, CA
*Villareal, Sylvia, M.D., Physician Specialist, Department of Public Health, City and County of San Francisco; Department of Health AIDS Minority Task Force; Board of Directors, California Children's Lobby, San Francisco, CA
*Williams, John, Executive Director, Children's Hospital at Stanford, Palo Alto, CA

THE CRISIS IN HOMELESSNESS: EFFECTS ON CHILDREN AND FAMILIES (2/24/87)

Ayres, Rebecca, Elizabeth, NJ
*Boxill, Nancy A., Ph.D., Associate Professor, School of Social Work, Atlanta University, Atlanta, GA
Brandwein, Ruth A., Ph.D., M.S.W., Dean, School of Social Work, State University of New York at Stony Brook, NY
*Bucy, June, Executive Director, National Network for Runaway and Youth Services, Inc., Washington, DC
*Diaz, Yvette, age 12, Hotel Martinique, New York, NY
Duggan, Dennis, Executive Director, and James Gamble, Deputy Director, San Antonio Metropolitan Ministries, San Antonio, TX
*Fagan, Tricia, Outreach Coordinator, Association for Children of New Jersey, Newark, NJ, accompanied by Ciro A. Scalera, Director, Association for Children of New Jersey, Neward, NJ
*Foscarinis, Maria, Washington Counsel, National Coalition for the Homeless, Washington, DC
*Mascitti, Valerie, Director, Homeless Project, Advocates for Children of New York, Long Island City, New York, NY
*McChesney, Kay Young, Ph.D., Director, Homeless Families

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* Testified before the Select Committee

Project, Social Science Research Institute, University of Southern California, Los Angeles, CA
*McMullan, Lisa and Guy, parents, Dundalk, MD, accompanied by Jamie, Ryan, Morgan, and Ryder McMullan
Rivers, Joseph, President, Orphan Foundation, Washington, DC
Robinson, Marcia President, Junior League of Atlanta, and Lynn Merrill, Board Chairman, Atlanta Children's Shelter, Atlanta, GA
Scalera, Ciro A., Director, Association for Children of New Jersey, Neward, NJ
*Wright, James D., Ph.D., Principal Investigator, National Evaluation, Johnson-Pew Health Care for the Homeless Program, Social and Demographic Research Institute, University of Massachusetts, Amherst, MA

CHILD ABUSE AND NEGLECT IN AMERICA: THE PROBLEM AND THE RESPONSE (3/3/87)

Anderson, James C., M.D. Richmond, VA
*Besharov, Douglas, Resident Scholar, American Enterprise Institute, Washington, DC
*Green, Frederick C., M.D., President, National Committee for Prevention of Child Abuse; Professor, Child Health and Development, George Washington University School of Medicine, Washington, DC
*Krugman, Richard, M.D., Director, C. Henry Kempe National Center for the Prevention and Treatment of Child Abuse and Neglect, Denver, CO; Associate Professor and Vice Chairman, Department of Pediatrics, University of Colorado School of Medicine; Chairman, American Academy of Pediatrics, Task Force on Child Abuse and Neglect
*Massinga, Hon. Ruth, Secretary, Department of Human Resources, State of Maryland, Baltimore, MD
*Raphael, Pat, Massachusetts President, Parents Anonymous of Massachusetts, Boston, MA, accompanied Atkinson, Jeanette, State Coordinator, Parents Anonymous, Boston, MA
*Soulis, Jeanne, Assistant Director, Child Advocacy Services Center, Inc., The Children's Place, Kansas City, MO

CHILD CARE: KEY TO EMPLOYMENT IN A CHANGING ECONOMY (3/10/87)

Bahr, Morton, President, Communications Workers of America, Washington, DC
*Bridgers, Annie M., Parent, Washington, D.C.
Easterling, Barbara J., Executive Vice President, Communications Workers of America, Washington, DC
Freeman, Harry L., Executive Vice President, American Express Co., New York, NY
*Glynn, Tom, III, Deputy Commissioner, Executive Office of Human Services,Department of Public Welfare, Boston, MA
*Maniker, Terry, Parent, Bethesda, MD
*McPeak, Hon. Sunne, Chair, Contra Costa County Board of Supervisors, Concord, CA
*Miles, Sue, Coordinator and Instructor, Early Childhood Program, Waubonsee College, Sugar Grove, IL
*Robins, Philip K., Ph.D., Professor of Economics, University of Miami, Coral Gables, FL
*Sanders, Ronnie C., Director of Voucher Day Care, Department

of Social Services, Commonwealth of Massachusetts, Boston, MA
*Vicars, Richard, Vice President of Human Resources, Lincoln National Life Insurance Company, Ft. Wayne, IN, accompanied by Baker, Madeline, Child Care Administrator, Lincoln National Life Insurance Co., Ft. Wayne, IN
Zigler, Edward, Sterling Professor of Psychology, Yale University, New Haven, CT

CATASTROPHIC HEALTH INSURANCE: THE NEEDS OF CHILDREN
(3/23/87)

American Hospital Association
Association of Maternal and Child Health Programs
*Bachschmidt, Angie, on behalf of her son Robert, age 4, Washington, DC
*Battle, Constance U., M.D., Medical Director and Chief Executive Officer, Hospital for Sick Children, on behalf of National Association of Children's Hospitals and Related Institutions, Washington, DC
*Brown, Steven, age 22, accompanied by his mother, Mrs. Diane Fleming, Bethesda, MD
Cernoch, Jennifer, Ph.D., Director, Texas Respite Resource Network; and Marian Sokol, Ph.D., Director, Project ABC, San Antonio, TX
Coelho, Hon. Tony, Member of Congress from the State of California
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EXCERPTS FROM SELECTED REPORTS ISSUED IN 1987

Abused Children in America: Victims of Official Neglect

U.S. Children & Their Families:
Current Conditions and Recent Trends, 1987

Federal Programs Affecting Children, 1987

A Generation in Jeopardy: Children and AIDS

ABUSED CHILDREN IN AMERICA: VICTIMS OF OFFICIAL NEGLECT

A REPORT
OF THE

SELECT COMMITTEE ON CHILDREN, YOUTH, AND FAMILIES

U.S. HOUSE OF REPRESENTATIVES

One Hundredth Congress
First Session

together with

ADDITIONAL VIEWS

and

DISSENTING VIEWS

March 1987

ABUSED CHILDREN IN AMERICA: VICTIMS OF OFFICIAL NEGLECT

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INTRODUCTION

Abuse and neglect of children is an all too common fact of American life. This report confirms in detail, based on the most reliable data available, the increasing tragedy of child abuse and child neglect in America, as well as the decline in resources available to serve these children.

Preventing abuse and neglect of America's children is a goal we all share. To learn more about the status of child abuse in the United States, the Select Committee on Children, Youth, and Families conducted an extensive survey of the 50 states and the District of Columbia. Every state responded to the Committee's questionnaire and cooperated with our extensive follow-up activities to assure the accuracy of their responses.

Our objective was twofold: to determine what information was available about the extent of child abuse and neglect; and to learn what resources and services have been dedicated by States and the federal government to prevent and treat child abuse.

Based on the survey's results, it is clear that we are failing to do enough.

The facts are that reports of child abuse are rising, particularly child sexual abuse and child neglect. States report that cases are more serious and complex and that abused children are the victims of more seriously troubled families.

While increased public awareness has led to increased reporting of child abuse and child neglect, more than a majority of states report that the severe economic hardships on American families continue to be a primary contributor as well.

Despite these clear signals that the national tragedy of child abuse and child neglect is deepening, our report documents that States' capacity to address these crises, or to prevent them, has declined significantly and has fallen far behind the need. The commitment of public resources has been far from adequate; the greatest shortfall has come as a result of cuts in federal assistance.

In addition to insufficient resources, the majority of States report that their child protective service systems are strained, their staff overburdened, and their overall capacity to deal with all the cases seriously curtailed. Coordination among the agencies responsible for protecting abused children, including law enforcement agencies, remains difficult. As a result, some states are treating a smaller proportion of the universe of cases reported to them, or responding primarily to the more dramatic cases. In too many instances, states indicate, children suffering from neglect may be less likely to receive services of any kind.

An important finding of this report is that it is possible to prevent and treat child abuse with a variety of cost-effective programs. It is encouraging to note as well that States are placing greater emphasis on prevention and family preservation programs to prevent unnecessary placement of children away from their families. Nevertheless, the dual burdens of increased reports of abused and neglected children and declining resources have compelled many states to abandon or curtail their most effective prevention and treatment programs.

In addition to seeking State trends in reports of child abuse, we sought States' views about the adequacy of current policies and programs. We sought information about the principal barriers to improved services, and we sought information about needs, services, staff, effective programs and special initiatives. We asked as well for recommendations about how to improve current efforts.

Our findings are based on States' responses to our survey, and extensive follow-up communications from them. While our report shares the methodological limitations inherent in all non-experimental studies, we have added significantly to what is known about current State efforts to prevent and treat abused children. Consistent with Select Committee tradition, we have let the States speak for themselves as much as possible, reporting their data and comments.

Our purpose in preparing this report is to develop an information base which will aid both state and federal policymakers, as well as private agencies which serve abused children and those at risk of abuse.

Government action is not the only solution, but it is a necessary element of any successful strategy. We hope that this report will help government at every level, as well as private organizations and families themselves, to find better ways to prevent child abuse and child neglect and to devise better policies and services to address the needs of abused children and their families.

FINDINGS

REPORTS OF CHILD ABUSE, PARTICULARLY SEXUAL ABUSE, ON RISE

** In a survey of the 50 States and the District of Columbia, between 1981-85, the number of children reported to have been abused or neglected rose 54.9 percent. Between 1984 and 1985 alone, child abuse reports increased nearly 9 percent. In addition, many States reported increasingly more serious and complex cases.

** Among the three major child maltreatment categories, physical abuse, sexual abuse, and neglect, reports of sexual abuse rose the fastest. For the 29 States providing complete information, sexual abuse increased 57.4 percent between 1983-84, and increased 23.6 percent between 1984-85.

REPORTS OF CHILD NEGLECT CONTINUE TO INCREASE

** Child neglect continues to represent the majority of maltreatment cases (58.5% in 1985). States providing information by type of maltreatment report a continuing increase in the number of children reported to have been neglected between 1981-85. For 1984-85 alone, these States report an overall increase of 5 percent.

** Despite the large number of child neglect cases, several States indicate growing inattention to neglected children over the past decade as reports of sexual abuse have increased.

DESPITE INCREASED REPORTS OF CHILD ABUSE, STATES UNABLE TO PROVIDE NEEDED SERVICES

** A majority of States report staff shortages, inadequate training, high personnel turnover, and a lack of resources for staffing as the principal barriers to improved child protection and child welfare services.

** For the 31 States able to provide complete information, total resources to serve abused and neglected children increased, in real terms, by less than 2 percent between 1981 and 1985.

** In 27 of these States, resources to serve abused and neglected children declined in real terms, or failed to keep pace with rapidly increasing reports of child abuse. Between 1981 and 1985, States lost more than $170 million, in real terms, in Social Services Block Grant (Title XX) funds alone; for 27 States, Title XX was the largest source of federal funds, and for 15 of them, the largest single source of funds -- federal, State or local -- for providing services to abused and neglected children and their families.

** While child protection and child welfare services require the coordination of many agencies, including social services, health, education, and law enforcement, several States indicate that difficulty in coordinating these efforts is a barrier to better services for children.

STATES CITE TWO PRINCIPAL FACTORS LEADING TO INCREASED CHILD ABUSE REPORTS

** Nearly every State ranked public awareness as a primary factor resulting in increased reports of child abuse and neglect.

** Sixty percent of the States ranked deteriorating economic conditions for families as another primary factor resulting in rising reports of child abuse and neglect.

PREVENTION RECEIVING INCREASED ATTENTION; STATES EMPHASIZING FAMILY BASED SERVICES TO PREVENT UNNECESSARY PLACEMENT OF CHILDREN OUT-OF-HOME

** Expenditures for public awareness of child abuse and neglect have risen in 27 States. Thirty-eight States have recently established Children's Trust Funds to support prevention programs. Nearly half of the States offer parent education, while at least 15 States provide prenatal and perinatal services to high risk women and teenagers and their infants. In addition, several States provide preventive programs of respite care, crisis nurseries, and early screening for developmental disabilities, for some portion of the population.

** Citing the need for permanency in children's lives and dwindling resources available to aid abused children, States are increasingly providing services to strengthen and maintain families. Homemaker and parent aide services received higher funding in 22 and 17 States, respectively. Eighteen States reported that they are providing family preservation services.

COST-EFFECTIVE PROGRAMS PREVENT OR REDUCE CHILD ABUSE AND NEGLECT, STRENGTHEN FAMILIES AND REDUCE DEPENDENCY

** In addition to the many promising prevention programs, States identified 19 programs which, according to evaluations, have successfully prevented child abuse, improved family functioning, and avoided costly treatment.

** In addition to the many promising treatment programs, States identified 15 treatment programs which, according to evaluations, have reduced recidivism, enhanced parent-child interaction and prevented placement of children in foster care.

STATES LACK SUFFICIENT LAW ENFORCEMENT DATA AND INFORMATION ABOUT HOW FUNDS FOR CHILD ABUSE SERVICES WERE SPENT

** While nearly all States report involvement of Child Protective Services with law enforcement agencies, they cannot report the rate of indictment, prosecution and/or convictions related to child abuse and neglect, nor are they able to report the percent of substantiated cases of abuse and neglect which are referred to law enforcement authorities.

** Most States were unable to report what federal, state, or local resources they dedicated to six major services commonly provided to abused children, or children at risk of abuse. These services include: case investigation and assessment, substitute care, adoption services, casework and treatment services, child care, and staff training and education. In addition, the vast majority of States were unable to identify the number of children provided with each service.

U.S. CHILDREN AND THEIR FAMILIES: CURRENT CONDITIONS AND RECENT TRENDS, 1987

A REPORT

together with

ADDITIONAL VIEWS

of the

SELECT COMMITTEE ON CHILDREN, YOUTH, AND FAMILIES

U.S. HOUSE OF REPRESENTATIVES

One Hundredth Congress
First Session

together with

ADDITIONAL VIEWS

and

DISSENTING VIEWS

March 1987

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U.S. CHILDREN AND THEIR FAMILIES: CURRENT CONDITIONS AND RECENT TRENDS, 1987

INTRODUCTION

In 1983, the Select Committee on Children, Youth, and Families began an assessment of the conditions in which American children and their families live. Our first report portrayed in detail the social and economic circumstances of American families. Now, at the outset of the 100th Congress, we have updated that assessment with "U.S. Children and Their Families: Current Conditions and Recent Trends, 1987."

This is a report card on where we stand as a nation in terms of families' financial status, housing arrangements, and the educational and health status of our youth. Four years ago, we identified what appeared to be dramatic shifts in families' social and economic conditions and living arrangements. What this report demonstrates beyond a doubt is that these trends are not temporary phenomena. They have made a permanent imprint on the demographics of our society and they continue to create rigorous new challenges for American families. In some areas the pressures are intensifying.

This report shows, for example, that:

In 1982, 5.8 million families with children were headed by single women. By 1986, the number of female-headed families increased by nearly a quarter of a million. One out of four children under 18 now lives in a single-parent household.

In 1982, we noted that nearly a majority of young children lived in households where both parents, or the only parent present, worked. Today, that is a fact for a majority of American children 5 years old or younger.

When the decade began, 39 percent of married mothers with infants under age one were in the workforce. By 1986, a majority of these mothers with infants were in the labor force.

In 1982, we noted that the poverty rate for children had increased by nearly one-third between 1970 to 1981, from 15 percent to about 20 percent. In 1985, more than 20 percent of all children remain impoverished.

Progress in reducing infant mortality has slowed dramatically. Black infants continue to die at nearly twice the rate of white infants, and the gap has widened over the past five years.

Low-income children suffer disproportionately in their health status, with higher rates of chronic disability, and lower utilization rates of medical and dental services.

The new data also reveal signs of progress:

Student SAT scores, rebounding in 1982 after a steady slide since the early sixties, continue to show modest increases through 1985.

While drug use among high school seniors remains high, it has declined steadily between 1981 and 1985; cocaine use, however, continues to rise.

> In 1985, 67 percent of all black elementary school children lived in families where one or both parents finished high school, up by nearly one-third since the beginning of the 1980s.

This compilation is not intended to be comprehensive, nor does it use every statistical series available. It includes only those data for which there are reasonably reliable national measures. Nevertheless, it should be noted that national data often mask regional and local differences.

By adding a great deal of new information, this report presents a clearer and more comprehensive picture of this nation's children and families than was possible before. We have included previously unavailable data on Hispanic children, foster children, adopted children and children with various health and mental health problems, and children's health insurance coverage.

Yet, the dearth of solid, national statistics on these and many other groups of children, such as Native American children, children of immigrants, handicapped children, and children of homeless and displaced families, continues to make the development of responsive policies affecting these groups difficult.

Beginning with our first report, the knowledge gathered by the Select Committee on Children, Youth, and Families has added measurably to the information base of the Congress, and has sharpened substantially the debate on problems facing America's children, youth and families. The evidence of the past four years alone signals changing circumstances that demand intelligent and creative responses from families, institutions, and government at all levels. We hope that this new report, which confirms profound changes in the lives of American families, will further enhance our ability to make sound policy choices.

ACKNOWLEDGEMENTS

The Committee wishes to thank Child Trends, Inc. for compiling this report. Child Trends is a not-for-profit research organization dedicated to improving the scope, quality, and use of statistical information about children and families.

The preparation of this report was made possible by Grant No. SES-8501616 from the National Science Foundation, for support of activities aimed at "Improving the Basic Research Potential of Federal Statistics on Children, Youth, and Families," and by supplementary support provided by the Office of the Assistant Secretary for Planning and Evaluation of the U.S. Department of Health and Human Services.

George Miller,
Chairman,
Dan Coats,
Ranking Minority Member.

FEDERAL PROGRAMS AFFECTING
CHILDREN, 1987

A REPORT
OF THE

SELECT COMMITTEE ON CHILDREN, YOUTH, AND FAMILIES

U.S. HOUSE OF REPRESENTATIVES

One Hundredth Congress
First Session

March 1987

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LETTER OF SUBMITTAL

February 23, 1987

Honorable George Miller
Chairman, Select Committee on Children,
Youth, and Families
House of Representatives
Washington, D.C. 20515

Dear Mr. Chairman:

In response to your request, I am submitting a revision and update of the report, "Federal Programs Affecting Children." The report provides information on income, nutrition, social services, education and training, health, housing, and tax programs as they relate to children and their families. Categories of information on each program, including years of data provided, are the result of your request and subsequent negotiations with staff. Twenty-six analysts from six Congressional Research Service divisions and offices contributed program information. The report was coordinated by Sharon House and Sharon Stephan, Specialists in Social Legislation of the Education and Public Welfare Division.

We hope this report will serve the needs of your committee as well as those of other committees and Members of Congress concerned with Federal programs affecting children.

Sincerely,

Joseph E. Ross

Joseph E. Ross
Director

Enclosure

FOREWORD

In January, 1984, the Select Committee on Children, Youth, and Families issued the first comprehensive compilation of Federal programs which directly affect children and their families. Now, we have updated that report with "Federal Programs Affecting Children, 1987".

This report, prepared by the Congressional Research Service, continues to further our goal of providing Congress with a broad base of the most current information available concerning programs and policies as they impact on children, youth, and families.

Like the earlier report, we expect this updated reference work to serve as a valuable tool for Congress as well as for groups and individuals interested in how the Federal Government addresses the needs of children and their families.

George Miller
George Miller
Chairman

Dan Coats
Dan Coats
Ranking Minority Member

A GENERATION IN JEOPARDY: CHILDREN AND AIDS

A REPORT
of the
SELECT COMMITTEE ON CHILDREN, YOUTH, AND FAMILIES

U.S. HOUSE OF REPRESENTATIVES
One Hundredth Congress
First Session

together with
ADDITIONAL VIEWS
and
DISSENTING MINORITY VIEWS

December 1987

A GENERATION IN JEOPARDY: CHILDREN AND AIDS

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Introduction

AIDS (Acquired Immune Deficiency Syndrome) has rapidly become the Nation's number one public health threat. It has already taken the lives of more than 26,000 Americans, principally adults, and has devastated thousands more.

But AIDS is not limited to adults. It has already killed hundreds of children and threatens to kill thousands more, many of them very young.

As a nation we have failed to meet this terrible challenge, which only promises to worsen.

While the numbers of children who have AIDS and the AIDS virus remain low, they are increasing geometrically; consequently, the threat must be taken seriously.

To help understand the complexities of AIDS and its impact on children and teenagers, the Select Committee on Children, Youth, and Families has conducted several hearings and culled the most up-to-date research and information. We have compiled and examined expert testimony, evolving knowledge, and emerging implications for our medical, educational and social services systems.

This report presents what we know about the threat of AIDS to infants, young children and teenagers, and how we can prevent its escalating toll. We recognize the limitations of any study, given the rapid advances in our knowledge and understanding of AIDS and its implications. We also recognize that every opportunity taken to focus attention on these issues may save lives.

Increasingly, those with the least access to information and fewest available resources -- low-income minority women and children -- are facing the greatest risk. We know that adolescents are especially vulnerable, because they are prone to engage in high risk behaviors that can lead to AIDS infection.

There is as yet no cure, vaccine or satisfactory treatment for AIDS. But it can be prevented. Individuals can protect themselves and reduce the risk of infection.

Surgeon General C. Everett Koop, the chief public health officer of the Nation, has stated that abstinence provides the only certain way to prevent the spread of AIDS through sexual contact. We agree. But, as Dr. Koop has emphasized, "because about 70% of adolescents are sexually active...if they haven't listened to the message of abstinence or monogamous relationships on a long-term basis, you have to introduce such things as condoms."

In the face of this epidemic, we must put aside ideology and marshall every available educational, medical and social service tool to address the AIDS epidemic.

If we fail to act now to limit the widening spread of AIDS, the public health threat of the 80's will become the public health and economic disaster of the 90's. Thousands of children will be lost; their families devastated. And the nation will be left reeling from the staggering and uncontrollable costs in lives and money.

We hope this report will serve to underscore the potential threat to children and youth, to fuel greater efforts to prevent the spread of AIDS and to improve care for those already infected by this deadly disease.

George Miller, Chairman
William Lehman
Patricia Schroeder
Lindy (Mrs. Hale) Boggs
Matthew F. McHugh
Ted Weiss
Beryl Anthony, Jr.
Barabara Boxer
Sander M. Levin
Bruce A. Morrison
J. Roy Rowland
Gerry Sikorski
Alan Wheat
Lane Evans
Richard J. Durbin
Thomas C. Sawyer
David E. Skaggs

FINDINGS

INFANTS AND YOUNG CHILDREN

AIDS RAPIDLY EMERGING AS MAJOR HEALTH THREAT TO LARGE NUMBERS OF INFANTS AND YOUNG CHILDREN

- * While still a small proportion of the total AIDS population, the cases of AIDS among children under 13 increased over 60% (from 420 to 691) from January 1987 - November 1987.
- * Experts estimate that for every child with active AIDS, several others are infected.
- * The Public Health Service predicts a nearly 350% increase by 1991 to 3,000 cases; some experts predict as many as 10,000 to 20,000 pediatric AIDS cases by 1991.

ALREADY STRAINED SERVICES FOR PRENATAL CARE, FAMILY PLANNING AND DRUG TREATMENT, FACED WITH SOARING NUMBER OF WOMEN WITH OR AT RISK OF AIDS

- * Nationally, over 3,000 AIDS cases have been reported in women, most of whom are of childbearing age.
- * This number is expected to increase 600% to over 20,000 by the end of 1991.
- * 30% - 50% of the babies born to HIV-infected women are also infected.
- * In New York City, about 3% of women of reproductive age (approximately 50,000) are infected with HIV; most were exposed to the virus through intravenous drug use or sexual contact with an HIV-infected individual.

AIDS CLAIMING MAJORITY OF YOUNG VICTIMS IN COMMUNITIES LEAST ABLE TO FIGHT BACK

- * Minority children, many of whom face urban poverty, poor health, lack of access to adequate care, and educational disadvantage, comprise the vast majority of pediatric AIDS cases.
- * While black children are 15% of the total U.S. child population, 54% of all pediatric AIDS cases are black.
- * Hispanic children are 10% of the child population, but 23% of the childhood AIDS population.
- * White children, 75% of the population, represent 22% of all pediatric AIDS cases.

WHILE EXPANDED HOME AND NON-HOSPITAL BASED SERVICES PROMISE MORE HUMANE AND COST-EFFECTIVE CARE, HIV-INFECTED CHILDREN CHIEFLY TREATED IN EXPENSIVE IN-PATIENT HOSPITAL CARE

- * Hospital care for infants born with AIDS can cost more than $200,000 per year per child.

- In contrast, Hale House Cradle, a planned group home in New York City for children with AIDS, is expected to cost $161 per day, or $58,765 per year for treatment and care, in contrast to $600 per day or $219,000 per year for acute care in a hospital.

- The St. Clair's Home, a transitional foster care facility in Elizabeth, New Jersey, has been providing home care since May 1987; at a yearly operating budget of $200,000, its five beds have been continously occupied.

PEDIATRIC AIDS THREATENS ALREADY OVERBURDENED FOSTER CARE SYSTEM

- Declining numbers of available foster homes combined with growing numbers of medically fragile and drug-exposed children have made appropriate placement of medically fragile children exceptionally difficult.

- Reduced availability of foster care has resulted in lengthy hospital stays for growing numbers of abandoned or orphaned children with or at risk of AIDS.

- New York City reported in July 1987 that at least 30 children with AIDS were boarding in hospitals. These "boarder babies" had been orphaned or abandoned and were awaiting foster care placement.

- Los Angeles County reported a 1000% increase between 1981 and 1986 in the number of infants and toddlers needing foster care for drug-related reasons, and increased referrals of sexually abused children -- both circumstances which place children at risk of AIDS infection.

ADOLESCENTS

NUMBER OF REPORTED AIDS CASES AMONG TEENS LOW, BUT ADOLESCENT BEHAVIORS PLACE THEM AT RISK

- While AIDS cases among 13-19 year olds represent only 0.4% of the total 47,298 reported AIDS cases, cases among this age group increased by 54% between January-November 1987 (from 127 to 195).

- By age 20, 70% of girls and 80% of boys have engaged in sexual intercourse at least once.

- Sexually active teens have the highest rate of sexually transmitted diseases among heterosexuals of all age groups.

- Increased heterosexual transmission of AIDS among teenagers and young adults has been confirmed by recent research.

ADOLESCENTS WITH HEMOPHILIA MOST HIV-INFECTED TEEN GROUP TO DATE

- 80% of AIDS cases among 11-17 year old males are hemophiliacs.

- 22%-75% of hemophiliacs have tested positive for AIDS antibodies; with the future safety of the blood clotting factor assured, the virus will no longer be transmitted in this way.

RUNAWAY AND HOMELESS YOUTH, AND MINORITY YOUTH IN URBAN CENTERS AT GREATEST RISK OF HIV INFECTION AND HARDEST TO REACH

- Out-of-school, runaway and homeless youth risk becoming infected because of higher rates of drug abuse and prostitution, and other behavior associated with HIV transmission.

- Minority youth also are at greater risk of AIDS infection due to their higher rate of sexually transmitted diseases, and their higher concentration in urban areas where the AIDS virus is prevalent.

ADOLESCENTS HOLD INAPPROPRIATE ATTITUDES AND BELIEFS ABOUT THEIR RISK OF AIDS INFECTION; PREVENTION DEMANDS APPROPRIATE AND CLEAR SEX EDUCATION BEGINNING AT EARLY AGES

- Only 15% of sexually active youth surveyed reported changing their sexual behavior to prevent contracting AIDS; only 20% of those who changed their behavior used effective preventive methods.

- Teens' denial of vulnerability and tendency to experiment and take risks makes AIDS education by itself insufficient.

- Only half of the largest U.S. school districts are providing AIDS education and prevention programs; programs to reach high-risk, out-of-school youth lag even further behind.

THE FEDERAL RESPONSE

FEDERAL EFFORTS TO COMBAT AIDS UNDERFUNDED, UNCOORDINATED, AND INSUFFICIENT

- A 1986 National Academy of Sciences report charged that the federal AIDS education effort was "woefully inadequate in terms of both the amount of educational material made available and its clear communication of intended messages."

- An August 1987 General Accounting Office review of AIDS prevention and the Administration's proposed 1988 budget reported a consensus of experts that federal efforts so far have been underfunded, uncoordinated, and insufficient.

LITTLE ATTENTION AND MONEY TARGETED ON AIDS PREVENTION AND TREATMENT FOR CHILDREN AND YOUTH

- Although children and youth are likely to benefit from most federal spending on AIDS, in FY 1987, only $6.5 million was made available by the Centers for Disease Control for school health prevention efforts. Only $16 million of the Administration's $422 million FY 1988 request for AIDS research at the National Institutes of Health would target children.

- $7.5 million of the National Institutes of Health's $252 million AIDS research budget for FY 1987 was dedicated to research exclusively on pediatric AIDS.

ADDITIONAL MINORITY VIEWS OF HON. DAN COATS, RANKING MINORITY MEMBER; HON. FRANK WOLF; HON. NANCY JOHNSON; HON. BARBARA VUCANOVICH; HON. JACK KEMP; HON. GEORGE WORTLEY; HON. RON PACKARD; HON. BEAU BOULTER; HON. DENNIS HASTERT; HON. CLYDE HOLLOWAY

The House Select Committee on Children, Youth and Families had its most active year in 1987, conducting 19 hearings in Washington D.C. and throughout the country, as well as issuing two major reports on child abuse and AIDS. We are pleased that this Committee has been so productive, assisting to better define the problems facing families and children in America and searching for possible solutions to those problems.

Some hearing topics were more focused upon issues now drawing significant political attention and which have always been of major concern to this Committee, such as child care and changing family economic opportunities. Topics such as AIDS and homelessness, where the Committee focused on the problems of children and youth, have also become of such national importance to require continuing investigations.

Some of the hearing topics have been more exploratory, initial investigations of topics, such as "Alternative Reproductive Technologies" and "Race Relations and Adolescents." Hearings such as these may arise because of a heightened interest driven by events such as the "Baby M" case and the Howard Beach incident, but have a strong possibility of being problems that will need to be closely watched as our society continues to change.

Hearings were also held on topics of continuing concern that may not receive as much attention in the news media, but that continue to be very important such as foster care and adoption, infant mortality, child abuse, and education.

As the Minority on the Committee, we as Republicans have little control over the final hearing topics and have expressed concern that the hearings have become so narrowly defined that the larger picture is too often lost.

While we need to look at problems as they affect children, such as AIDS, we cannot ignore the fact that children get AIDS through adults and thus adult behavior is very relevant as well. Obviously, other problems such as homelessness, need to be looked at from an adult behavioral angle as well as the impact upon children.

Many of the hearing topics also interact with each other. This fact is one of the primary reasons for the existence of this Committee. If we are to avoid the pitfalls of the proliferation of committees' and sub-committees' fragmented approach to children, youth and families that led to the creation of the Select Committee in the first place, we must focus on inter-relationships, holistic approaches, and creative approaches, and not get locked into the rigidity of the existing legislative structure.

We also feel that while particular programs that address the problems are important, that larger questions of attitudes and mediating institutions such as families are at least as important, if not more important. We do not agree with any implications that problems are going to be solved simply through more national programs. This view is reflected in how we as Republicans approached a number of these hearings (e.g. a witness from the

Association of Marriage and Family Therapists at the hearing on "Eating Disorders").

In reading through the fact sheets and witness summaries of 1987 Committee hearings, it also needs to be understood that the Republican Minority by definition only selects a minority of the witnesses and that the fact sheets are developed by the Democrat Majority staff. While the summaries are a reasonably straightforward representation of what was said (and individual Committee hearing records are available for those who want more complete information), the majority of what was said by the witnesses obviously more completely reflects the Democrat Majority's positions than it does the Republican views.

We have some agreements and some disagreements with the Democrat witnesses and their fact sheets. In these views, rather than give a point-by-point recitation of differences, we have chosen to highlight a number of key points that we as Republicans attempted to bring out in the hearings throughout 1987.

Key Republican Themes in 1987

1) Family-based approaches to problems.
2) Fostering the development of personal responsibility.
3) Encouraging the building of character and values.
4) Opposing ideas that undermine strong families and values.
5) Targeting programs to the needy.
6) Encouraging more efficient utilization of resources so more can get to those most in need.
7) Featuring public/private partnerships, private sector, local and state solutions rather than a primary emphasis on the

responsibility of the national government to solve all problems.

8) Highlighting prevention programs.

Specific Applications of Those Themes

1) Family-based approaches to problems.

a) In as many hearings as possible we attempted to identify those witnesses who were pro-family and who believed in the importance of developing family strengths.

"Eating Disorders"

> Moley: "If you extend that analogy, you could see the family as sort of constituting a potential immune system and what you need to do is strengthen the immune system because there may be nothing you can do about the biological propensity, but the family can make an impact of a positive nature."

"Changing Economics in the South"

> Carter: "I think one of the things that is at the root of all this is what happens in the individual family, what kind of support are those young people getting at home in terms of encouragement to complete high school education, consider junior college or technical institute or something like that."

"Parents: The Missing Link in Education Reform"

> Kamps: "Today, however, there remains little doubt that parent involvement greatly improves the child's academic and social success at school and throughout his life."

b) We highlighted when possible the fact that individual problems were often rooted in family problems.

"Crisis in Homelessness"

> Bucy: "Every study indicates that homeless youth were most often removed from families deemed abusive or neglectful by authorities, set upon by a carousel of repeated 'placements,' and are eventually rejected, emancipated, or lost in the records by that helping system."

c) We stressed that family systems need to be the target of intervention and not just the behavior of the individual family member. We highlighted this point in numerous hearings. For example:

"Continuing Crisis in Foster Care"

> Loprena: "Long-term foster care should not be rewarded...the corporate parent is no substitute for a permanent, loving family."
>
> Oliver: "It is imperative that a national family policy be established that mandates all families at risk of having children placed into foster care receive intensive preventive services except, of course, in emergency, life threatening or imminent danger situations...Such a policy should also require that interdisciplinary services aimed at meeting the needs of individual family members be coordinated into a comprehensive family plan for the family as a whole."

"Preventing Out of Home Placement"

> Nelson: Successful programs focus on family systems of interaction and not on individual family member's behavior.

"Children's Mental Health"

> Davis: Intervention must be family based, intervention must be early, treatment must be in the community and in the homes. "It must strengthen the natural support system present in the child's family and social environment."

2) Fostering the development of personal responsibility.

"Infancy to Adolescence"

> Price: "Successful programs either give people new skills to cope more effectively or provide support in the context of life transitions...A number of programs, in fact, use both of these strategies to alter the person's developmental course."

"Changing Economics in the South"

> Carter: "Employers listed a lack of basic interpersonal skills as a chief reason for employees failing to move up a company's career ladder."

"Preventing Out of Home Placement"

> Nelson: The National Resource Center's recent survey of 115 family-based service workers in six states were asked to rank factors of greatest

importance to an effective program ranked "empowerment of families to assume greater responsibility and self-determination over their own lives" first in importance.

"American Families in Tomorrow's Economy"

> Carlson: "The record in other nations and from earlier times shows over and again that the progressive socialization of early child care, housing, and education works, in general, to weaken the private family economy, to erode further the independence of families relative to government, and to draw government officials into what might be called 'lifestyle engineering.'"

"AIDS and Teenagers"

> Mark: "There are no effective public health strategies for containing the virus epidemic that do not endanger some civil liberties. What we must do is balance individual rights against the public's right to escape the epidemic to determine what the compelling national interest is."

"Parents: The Missing Link in Education Reform"

> Kamps: "HIPPY is, also, a parent education program designed to change the attitudes of parents as it helps them recognize the responsibilities to their children. Some parents believe it is the responsibility of the school system to educate their children and theirs alone."

3) Encouraging the building of character and values.

"Race Relations and Adolescents"

> Flake: "The reality is that we need to address this whole problem of images, because the only way we can change the mind, the attitude of our young adolescents, is to deal with the reality that what they see in most instances of blacks is a very negative kind of projection."

"Infancy to Adolesence"

> Kenney: "The Community of Caring is a values-based health and education program that...uses two approaches...a curriculum which emphasizes values of caring and respect and thus promotes the moral development of members of the community and the creation of a community that includes the home."

Botvin: "One type of successful program strategy focuses primarily on the social influences believed to promote substance abuse: teaching students techniques for effectively resisting social influences to smoke, drink, or use drugs such as how to effectively and confidently say 'no' when confronted by peer pressure to smoke."

"AIDS and Young Children"

Koop: "Couples who maintain a mutually faithful, monogamous relationship are protected from AIDS through sexual transmission."

"AIDS and Teenagers"

Lutton: "In the face of what we know about AIDS, about how it is spread, and by what sort of activity, schools should not teach or facilitate 'value-free' sexual acts, just as they shouldn't teach safe methods of self-administering intravenous drugs."

4) Opposing ideas that undermine strong families and values.

"Alternative Reproductive Technologies"

Doerflinger: "Without ignoring the needs of infertile couples, society must take care that procedures designed to help build families will not unintentionally undermine the social and legal status of the family."

Marshall: Contended that the use of amniocentesis to detect prenatal defects "usually amounts to a search and destroy mission." Surrogacy should be abolished, in part, because it exploits women and treats children as "chattel."

"Women, Violence and the Law"

Sears: "Then we have...the fellows who would, for example, tie their wives with the ropes, with the knots that they learned from pornography. There are books on staff that my staff purchased here in Washington, D.C. called 'How to Rape a Woman,' and 'How to Molest a Child.' People, of course, argue that these are protected materials and should in no way be censored."

"We found that pornography is used to lower the inhibitions of many of our victim children...You say 'What does this have to do with women?' Children grow up and a substantial number of the men who go on to be abusers were abused children themselves. Pornography plays a significant role in the training of our young people to become sexual abusers; trains young people to view women

> as objects; view women as something unworthy of respect."
>
> "The largest category of consumers of pornography in America are 12- to 17-year-olds. They are in the real world. This is not a consenting-adult issue. This is the training material for the youth of America."
>
> Pope: "Being commanding officer of the unit, and having the availability of these sexual reports, in 1977, I did a research project where I looked at 38,000 case histories and found that 41 percent of those reports indicated that, in fact, pornograhic materials were used just prior to or during the actual act."
>
> "I can remember talking to one young man who was 19 years old, he said: 'It excited me and then I got to thinking about it and I wanted to know how it felt.' This is this young man's answer. He wanted to know how it felt to rape a woman and kill her... And when we arrested this young man and searched his home, we found a pornographic magazine depicting this very thing that he had done. By the way, he had stabbed her 57 times."

5) Targeting programs.

"Child Abuse and Neglect in America"

> Besharov: "The current flood of unfounded reports is overwhelming the limited resources of child protective agencies...As a result, children in real danger are getting lost in the press of inappropriate cases."

"Infancy to Adolescence"

> Price: In response to the question - what do successful programs have in common? - he first listed that "the programs are targeted. The programs focus on groups for which there is a reasonably well-defined understanding of their risk status."

"AIDS and Young Children"

> Rogers: "The biggest problem [in transmitting AIDS to young children , really is the drug abusing population." (Dr. Martha Rogers, MD, Chief of Pediatric and Family Studies, Centers for Disease Control, Feb. 1, 1987; Republican sheet for hearing)

"Florida's Economic Future and the Child Care Crisis"

> Carpenter: Viewed the child care subsidy for

> welfare mothers (to allow them to work) as "the difference between starvation and survival. It offers the mothers who can get into the program an alternative to abandoning their children."

"AIDS and Teenagers"

> Crenshaw (written testimony): As I mentioned above, there are heated debates among the adults about how to educate our children and there is great interest in doing so, but we are very far from implementing effective educational programs that have potential to impact these young people. Even more serious, is that there is no substantial testing occurring in these age groups. In the tradition of our approach to AIDS, we only begin testing a group once it becomes known that they are already infected. It would be so important to change this pattern, learn from our past mistakes, and do it differently with our children. We could test children before they are widely infected, monitor them closely, and prevent spread by being alert to the earliest signs."

"Parents: The Missing Link in Education Reform"

> Kamps: "HIPPY (Home Instruction Program for Preschool Youngsters) is a home-based program for the educational enrichment of disadvantaged preschool children and the promotion of increased awareness by their parents of their own strengths, potential and importance as their children's first and primary teacher."

6) Encouraging more efficient utilization of resources so more assistance can get to those most in need.

"Children's Mental Health"

> Shanley: "There is no comprehensive, integrated method for assessment that looks holistically at the child as a single system that has social, familial, and education problems...The uncoordinated involvement of these multiple sectors in providing service must be considered a principle cause of the ineffective, discontinuous, unresponsive care to the children and is anathema to the meaning of 'system.'"

> Davis: "The strengths of our program lie in its development as a comprehensive system encompassing a range of service elements instead of being limited to one specific element of outpatient services, and its long-term commitment to a philosophy of early intervention and treatment of children and adolescents while

> keeping them in the community and in their homes whenever possible."

7) Featuring public/private partnerships, private sector, local and state solutions rather than a primary emphasis on the responsibility of the national government to solve all problems.

"Child Care: Key to Employment in a Changing Economy"

> Baker: "One of the things that has happened with our program is that we have a tremendous positive kind of relationship with those family day care providers who are registered with our program. So they are the ones who are putting the word out among themselves that it's wonderful to be affiliated with Lincoln National Life's Child Care Services."

"Florida's Economic Future and the Child Care Crisis"

> Crosby: "We do not provide this benefit (child care) for humanitarian reasons, but because it makes good business sense."

> Carpenter: "The division of cost between State general revenue and Federal Social Service Block Grant is an appropriate one, and in this State of Florida, a requirement for local contributory participation is also in place so that local county government and local United Ways and foundations trigger the State's participation, and this is appropriate. It shares the cost and shares the ownership of the program."

"The Continuing Infant Mortality Crisis in Illinois"

> Weigel: "However, every problem has a solution. And we, at least, in the hinterlands have decided that we are concerned. The obstetricians in my area are concerned about it and they have decided to do something about it. Through the efforts of the Illinois Public Health and our Health Department, we were able to get a grant of $265,000 from the State, to be matched by the County, for prenatal care from private physicians. What we are doing in the County is we are given an additional monetary award as a bonus to cover just the costs of what malpractice would cost them, and it is offically called their Participating Achievement Award. Our obstetricians are running the program through the local medical society. They are enthused about the program...The most important facet of our program is that it is being run locally by the local health department through a medical society for the local obstetricians. These patients are

> going to be treated as private patients. And they are not going to have to wait three or four weeks before seeing a doctor. Nor are they going to have to worry about having to go to some high risk clinic, because they are going to be taken care of just as well as a patient who has insurance and is paying the bill right."

"Parents: The Missing Link in Education Reform"

> Winter: "Although this program is delivered by the public schools, it has been a public/private partnership from the outset. I think they feel there should always be a local commitment to the program through in-kind or whatever dollars the district can provide, because that is our policy in Missouri. We don't fund any of our educational programs fully through the state, but the degree of local involvement or commitment varies from one district to another, as does the cost. The major cost, of course, is the parent educator. Most parent educators are hired on a part-time basis because that works well into the schedule of young parents who are excellent in this role. That makes the program very cost effective."

8) Highlighting prevention programs.

"Child Care: Key to Employment in a Changing Economy"

> Miles: Quality programs have shown these results after twenty years in Weikart's studies. The programs have led to teenagers who more frequently complete high school and attend college. Acts of delinquency have been reduced and "one program estimated that every $1 invested led to a return of $4.75 in savings as a result of lower special education costs, lower welfare costs, and higher worker productivity as the children matured."

"AIDS and Teenagers"

> Lutton: "Public schools should teach children that the only truly healthy sexual behavior is abstinence until marriage."

"Children's Mental Health"

> Davis: "From time to time, failure of statistical measures of cost and efficiency to fully recognize the additional professional time required by the multi-faceted nature of children's problems has made the struggle more difficult. The bases of our survival have been strong community relationships and a long-term local administrative commitment to the preventive value of a children's program."

"AIDS and Teenagers"

> Crenshaw (written testimony): 'Recommendations for Teenagers - 1) Since most teenagers cannot afford the testing or would be too embarrassed to ask for it, the best insurance is abstinence or, as one teenager put it, "I am an inactive heterosexual". There is a premium on virginity today as a result of health issues rather than moral issues. 2) Be abstinent ...until ready to establish an exclusive sexual relationship. Do not have more than one partner. Do not have sex without condoms and spermicide. Do try to be sufficiently resourceful to get tested before starting a sexual liaison. Do not use drugs or alcohol, these impair judgement, and do not share needles, this transmits the virus. If you have questions or find some of these suggestions impossible, do talk with your school counselor, your neighbor, your friend, or some responsible adult. 3) There is no safe sex with an infected partner, only degrees of risk. Do not have sex with someone who is infected and do everything reasonable within your power to ensure before having sex with anyone that your prospective partner is uninfected. 4) The only way to tell if someone is infected is through a series of blood tests. While they aren't 100% reliable they are quite close and quite good tests, if interpreted correctly. Infected carriers look healthy, feel healthy, and usually don't even know that they are infected themselves."

ADDITIONAL REPORTS FOR 1987

"Abused Children in America: Victims of Official Neglect"

The Republican Minority issued both additional and dissenting views to this report.

The additional views, titled "Aborted Children in America: Victims of Legal Abuse," were signed by 11 of the 12 Republican Members of the Committee. These Members feel that any definition of child abuse should include abortion since every year more than one and a half million babies are killed.

The dissenting views were signed by all 12 Republican Members of the Committee. The following is a summary of those findings:

* Child abuse is a serious and complex social problem.

* The interpretation of the data and the selectivity of the reporting are the factors causing the Minority dissent.

* The report is a compilation of state reporting statistics that yields a limited state snapshot of the tragedy of child abuse and neglect in America. As a snapshot, it is a very useful document.

* It should be emphasized that no standard definition of child abuse and neglect is adhered to by the States.

* The report confuses incidences of child abuse and neglect with reports.

* The report downplays a very important concern: less than half of all child abuse and neglect reports are substantiated.

* The rise in reports between 1981 and 1985 could be interpreted as the result of the increase in public awareness. It may be the case that a rise in incident rates indeed occurred, but that is not possible to determine from the data.

* Many States reported that changes in the reporting laws accounted for the increase in reports.

* We believe that we are not doing enough to strengthen family ties that would help prevent child maltreatment.

* There is some good news in terms of Federal and State

responses. Overall, the analysis of the Federal, State and Local funding during 1981-1985 shows, in constant dollars, a $37.7 million increase in public resources targeted for child abuse prevention and treatment. This represents a 1.9% increase.

* The report does not discuss the causes of child abuse.

* The most typical case of child maltreatment is not physical abuse or sexual abuse, but neglect.

* Many states have initiated some very creative programs in response to the high rates of child abuse reports: parent education programs, homemaker services, parent aides, respite care and crisis nurseries are all programs that are receiving additional state funds.

* We cannot over-emphasize the importance of the finding that existing legal and administrative structures continue to obstruct child protective services.

* The state "fact" sheets represent the responses of the employee(s) assigned to officially answer the survey. As such, the "facts" are subject to response bias in terms of the State's own agenda, especially with regard to budget items.

"A Generation in Jeopardy: Children and AIDS"

Dissenting Minority Views of Hon. Dan Coats, Ranking Minority Member; Hon. Frank Wolf; Hon. Barbara Vucanovich; Hon. Jack Kemp; Hon. Ron Packard; Hon. Beau Boulter; Hon. Denny Hastert; Hon. Clyde Holloway

The core of our dissent from the Majority report is based upon the following points:

1) Most children, especially infants, get AIDS from adults. If we are serious about protecting children from AIDS, the focus must be on stopping the spread of AIDS among adults as fast as possible. The Majority report never clearly states this basic truth.

2) The number one means of transmission of AIDS is through anal intercourse, most common among homosexuals. The Majority report not only does not clearly state this, it repeatedly downplays the pivotal role anal intercourse and homosexuality has played and continues to play in the AIDS crisis.

3) Infected homosexual IV drug-users, especially in inner cities and so-called "shooting galleries," have spread AIDS to heterosexuals. The numbers are still small, and since the CDC recently revised its definition of AIDS, it is not clear that the heterosexual spread of AIDS is growing. However, we face a potential epidemic among certain categories of heterosexuals (i.e. those abusing drugs and those married to bisexuals) and children infected by adults with AIDS.

4) This report indirectly hints at the truth that family, character, and responsibility are the keys to solving this problem, yet it pays only "lip service" at best to ideas that could produce real changes. The Majority report states no less than five times that 70% of teens are sexually active by age 20. Through repetition, they seem to want readers of this report to become conditioned to accept the

current level of teenage sexual activity is an unchangeable fact of life.

5) Condom failure rates guarantee that there is no such thing as "safe sex." It may be "safer sex" but, for example, it needs to be clearly stated that the failure rates in anal intercourse are hardly what most people would call safe.

6) The Majority report criticizes the level of funding available. We would argue that probably the biggest spending void at this time is in the area of preventing the disease. Spending cannot keep up with demand unless aggressive prevention is undertaken. We need more caring for the potential victims.

The preceding Minority views document our concerns about the AIDS crisis and the Majority report. The pain, agony and death of AIDS will not be stopped unless we honestly confront the key facts. Defining the problem correctly is a necessary first step to solving the AIDS crisis. The Majority introduction called for avoidance of ideology, yet in their failure to go beyond ideology, they are in danger of failing to help the generation that may be in jeopardy.

We need a reasonable, comprehensive national strategy against AIDS based on two principles - caring and responsibility. This must include the following elements: detection, prevention, education, treatment, and research. We need compassionate care for the individuals afflicted and responsibility toward potential victims.

These views are not a comprehensive national strategy as such but they hopefully point toward the direction we need to head. We are disappointed that the Committee report seems to only offer so little toward a comprehension of and a solution to the problem of AIDS and children.

Additional Dissenting Views: Hon. Thomas J. Bliley

Congressman Bliley submitted an additional dissent objecting to way the Committee handled the report, specifically the excluding of the Minority from the development of the report.

Dan Coats, Ranking Minority Member
Frank Wolf
Nancy Johnson
Barbara Vucanovich
Jack Kemp
George Wortley
Ron Packard
Beau Boulter
Dennis Hastert
Clyde Holloway

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